CROSSING THE LINE: *DAUBERT*, DUAL ROLES, AND THE ADMISSIBILITY OF FORENSIC MENTAL HEALTH TESTIMONY

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Psychiatrists and other mental health professionals often testify as forensic experts in civil commitment and criminal competency proceedings. When an individual clinician assumes both a treatment and a forensic role in the context of a single case, however, that clinician forms a dual relationship with the patient—a practice that creates a conflict of interest and violates professional ethical guidelines. The court, the parties, and the patient are all affected by this conflict and the biased testimony that may result from dual relationships. When providing forensic testimony, the mental health professional's primary duty is to the court, not to the patient, and she has an obligation to give objective and truthful testimony. But this testimony can result in the patient's detention or punishment, a legal outcome that implicates the mental health professional's corresponding obligation to "do no harm" to the patient. Moreover, the conflict of interest created by a dual relationship can affect the objectivity and reliability of forensic testimony.

A dual clinical and forensic relationship with a single patient is contrary to quality patient care, and existing clinical and forensic ethical guidelines strongly discourage the practice. Notwithstanding the mental health community's general consensus about the impropriety of the practice, many courts do not question the mental health professional's ability to provide forensic testimony for a patient with whom she has a simultaneous clinical relationship. Moreover, some state statutes require or encourage clinicians at state-run facilities to engage in these multiple roles. This Article argues that the inherent conflict created by these dual roles does not provide a reliable basis for forensic mental health testimony under Federal Rule of Evidence 702 and should not be admitted as reliable expert testimony by courts. Because dual relationships are often initiated due to provider shortages and the unavailability of neutral forensic examiners, this Article will also discuss the use of

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telemedicine as a way to provide forensic evaluations in underserved areas, especially those where provider shortages have prompted mental health professionals to engage in dual clinical and forensic roles. Finally, this Article argues that courts should exercise their powers more broadly under Federal Rule of Evidence 706 to appoint neutral and independent mental health experts to conduct forensic evaluations in civil commitment and criminal competency proceedings.

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INTRODUCTION

In 1982, a young black army sergeant was accused of stealing a stick of deodorant from the base where he worked.[1] When the military police went to the sergeant's home to investigate, they found other stolen property—blankets, tools, cans of food—enough to "fill[] a trailer truck."[2] Following his arrest, the army ordered that the sergeant be examined by a civilian psychiatrist, who diagnosed him as a kleptomaniac.[3] Because this diagnosis would have mitigated the

[1] Alan A. Stone, *Presidential Address: Conceptual Ambiguity and Morality in Modern Psychiatry*, 137 AM. J. PSYCHIATRY 887, 888 (1980) [hereinafter Stone, *Presidential Address*].

[2] *Id.*

[3] *Id.*

sergeant's criminal culpability, the army asked another expert to examine the sergeant; this time an army psychiatrist.[4]

The army psychiatrist spent weeks examining the sergeant.[5] And while the sergeant was told repeatedly that anything he said could be used against him at court martial, he nonetheless opened up to the army psychiatrist and shared many intimate details about his life. He had grown up poor in the segregated South, but was a good student and graduated from college with a literature degree. He was eventually drafted into the Korean War and remained in the army for the next twenty years.[6] As time went on, he became increasingly unhappy and resentful:

> He was convinced that life had cheated him because he was black and that the Army, in the work and position it gave him, continued to discriminate against him. Out of this sense of being cheated there grew a sense of entitlement, and he came to feel that he was justified in taking whatever he could whenever he could. He had no sense of being impulsively driven to steal Army property; instead, he stole with a sense of entitlement and reparation in protest of the racist world that had deprived him of his hopes.[7]

Ultimately, the army psychiatrist concluded that the sergeant did not have kleptomania, nor any other disorder that would negate his criminal responsibility for his actions.[8] The psychiatrist testified to this effect at the court martial. While testifying, he tried to avoid making eye contact with the sergeant, who sat in his dress uniform with his wife and small children seated next to him. When the sergeant was sentenced to five years of hard labor for his crime, the army psychiatrist knew "something terrible happened" and experienced a "sense of dismay that will not be dissipated."[9]

Dr. Alan Stone, a Professor of Law and Psychiatry at Harvard University, told this story, which became known as *The Parable of the Black Sergeant*, to the audience of the Thirteenth Annual Meeting of the American Association of Psychiatry and the Law (AAPL).[10] It was 1982, and Dr. Stone delivered the keynote address to the group in a speech he called *The Ethics of Forensic Psychiatry: A View from the Ivory Tower*.[11]

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4 *Id.*
5 *Id.*
6 *Id.*
7 *Id.*
8 *Id.*
9 *Id.*
10 Charles L. Scott, *Believing Doesn't Make It So: Forensic Education and the Search for Truth*, 41 J. AM. ACAD. PSYCHIATRY & L. 18, 19 (2013).
11 *Id.* In Stone's words, the speech was a "parable about racism, about guilt and forgiveness, and about psychiatric theory and practice." Stone, *Presidential Address*, *supra* note 1, at 887.

At the end of the story, Dr. Stone revealed that he was the army psychiatrist.[12] This story, and Dr. Stone's speech, inspired some of the first conversations within the psychiatric community about the ethics of dual relationships between psychiatrists and patients.[13]

When viewed within a contemporary forensic ethical framework, Dr. Stone did not in fact have a dual relationship with the sergeant: Dr. Stone did not have an existing therapeutic relationship with the sergeant, but rather performed a forensic evaluation, one in which he followed existing ethical guidelines by advising the sergeant about the purpose and parameters of the evaluation.[14] When Dr. Stone felt a treatment relationship developing with the sergeant, he believed the relationship was unethical, and therefore concluded that forensic psychiatrists "are without any clear guidelines as to what is proper and ethical."[15] And indeed, the disciplines of psychiatry and psychology had not yet developed an ethical framework for forensic mental health generally, or for the ethical problem of dual relationships specifically.[16]

Although psychiatrists regularly testified in court proceedings at this time, no one in the psychiatric community had yet spoken or written about the ethical concerns raised by the practice, and Dr. Stone's audience was, by all accounts, riveted.[17] The problem, as everyone in the room appeared to recognize, was that psychiatrists often engaged in dual-role relationships when they provided patients with clinical treatment in addition to giving forensic testimony in a legal proceeding involving the patient. These relationships raised troubling ethical concerns due to the different goals and expectations of forensic and clinical settings. When providing forensic testimony, as Dr. Stone did in the sergeant's court martial, a psychiatrist's primary duty is to the court, not to the patient, and she has an obligation to give objective and

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12 *See* Stone, *Presidential Address*, *supra* note 1, at 888.

13 *See* Scott, *supra* note 10, at 19.

14 Stone, *Presidential Address*, *supra* note 1, at 888 ("It is not clear why this black supply sergeant, despite being warned, told all this to the Army psychiatrist.").

15 Alan A. Stone, *The Ethical Boundaries of Forensic Psychiatry: A View from the Ivory Tower*, 36 J. AM. ACAD. PSYCHIATRY & L. 167, 167–68 (2008) [hereinafter Stone, *The Ethical Boundaries of Forensic Psychiatry*]. *See generally* Paul S. Appelbaum, *A Theory of Ethics for Forensic Psychiatry*, 25 J. AM. ACAD. PSYCHIATRY & L. 233 (1997) [hereinafter Appelbaum, *A Theory of Ethics*] (discussing Stone's speech and the forensic psychiatric community's response).

16 *See* Appelbaum, *A Theory of Ethics*, *supra* note 15, at 234 (noting that at the time of Stone's speech, "Forensic psychiatry still lack[ed] a *theory* of ethics by which to shape its behavior").

17 Paul S. Appelbaum, *Ethics and Forensic Psychiatry: Translating Principles into Practice*, 36 J. AM. ACAD. PSYCHIATRY & L. 195, 195 (2008) [hereinafter Appelbaum, *Ethics and Forensic Psychiatry*]; Scott, *supra* note 10, at 19.

truthful testimony.[18] In many cases, however, this testimony can result in the patient's detention or punishment, a legal outcome that implicates a treating psychiatrist's obligation to "do no harm" to the patient.[19] Moreover, when a testifying mental health professional also has a clinical relationship with an individual, that relationship can affect her ability to give objective and reliable testimony.[20]

As this Article will discuss, the fields of forensic psychiatry and psychology later developed comprehensive and robust ethical frameworks to guide mental health professionals who are faced with this ethical dilemma, and the fields themselves strongly discourage—but do not expressly prohibit—the practice. Notwithstanding these ethical guidelines and the inherent conflicts that arise from this practice, many courts do not question the mental health professional's ability to provide forensic testimony for a patient with whom she also has a clinical relationship, and some state statutes actually require clinicians in state-run facilities to perform these multiple roles.[21]

Although this type of conflict and resulting unreliable testimony can arise in a variety of litigation settings—from child custody litigation to civil and criminal cases—this Article limits its analysis to forensic evaluations that occur in civil commitment and criminal competency evaluations. Part I of this Article will discuss the medical and legal rules that govern dual relationships within the fields of psychiatry and psychology and within the legal system. Part II will examine the various harms that result from dual relationships, including harms to the patient and the therapeutic relationship, and harms to the legal system that occur when unreliable expert testimony is admitted in civil commitment and competency proceedings. This Part will also discuss why disclosure of the conflict is not enough to avoid these harms. Part III argues that forensic assessment by a patient's therapist does not generally provide a reliable basis for forensic testimony under the Federal Rules of Evidence and recommends that courts view such testimony with considerably more skepticism than is current practice. This Part recommends that state legislatures expand statutes permitting telebehavioral health[22] as a way to provide neutral forensic evaluations, especially in communities

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18 Appelbaum, *Ethics and Forensic Psychiatry*, *supra* note 17, at 196 ("[F]orensic psychiatrists should testify to what they believe to be true, regardless of whether such testimony favors or disadvantages the parties employing them.").

19 Appelbaum, *A Theory of Ethics*, *supra* note 15, at 236, 241; *see also infra* Section II.A.

20 PAUL S. APPELBAUM & THOMAS G. GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 235 (4th ed. 2007); *see also infra* Section II.B.

21 KIRK HEILBRUN, PRINCIPLES OF FORENSIC MENTAL HEALTH ASSESSMENT 68 (2001) (noting that in a review of legal standards governing the practice, "[n]o legal authority on this principle was located"); *see also infra* Section I.B.

22 *See* text accompanying notes 285–87 (explaining telebehavioral health).

where provider shortages have prompted psychiatrists and mental health professionals to engage in dual clinical and forensic roles. Finally, this Part also recommends that courts exercise their powers more broadly under Federal Rule of Evidence 706 to appoint neutral and independent mental health experts in civil commitment and competency proceedings.

I. DUAL CLINICAL AND FORENSIC RELATIONSHIPS

Psychiatry is a field of medicine that studies the "diagnosis and treatment of disorders of thinking, feeling, and behavior."[23] Forensic psychiatry is a subspecialty of psychiatry that applies psychiatric principles to legal questions and legal proceedings. One well known definition of forensic psychiatry is "the application of psychiatry to legal issues for legal ends, legal purposes."[24] Similarly, forensic psychology is "all forensic practice by any psychologist working within any subdiscipline of psychology."[25]

Psychiatrists, psychologists, and other mental health professionals are often asked to give testimony in legal proceedings ranging from family law to civil litigation, civil commitment, and criminal proceedings.[26] For example, a mental health professional might be asked to testify about the custodial fitness of a parent or the degree of trauma suffered by a civil plaintiff in a claim for assault. Similarly, a mental health professional might give testimony about whether a defendant is

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23 J. Richard Ciccone, Commentary, *Forensic Education and the Quest for Truth*, 41 J. AM. ACAD. PSYCHIATRY & L. 33, 33 (2013).

24 Seymour Pollack, *Forensic Psychiatry—A Specialty*, 2 BULL. AM. ACAD. PSYCHIATRY & L. 1, 2 (1974); *see also* ETHICS GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY § I cmt. (AM. ACAD. PSYCHIATRY & L. 2005) [hereinafter AAPL FORENSIC PSYCHIATRY ETHICS GUIDELINES], http://www.aapl.org/ethics.htm (defining forensic psychiatry as "a subspecialty of psychiatry in which scientific and clinical expertise is applied in legal contexts involving civil, criminal, correctional, regulatory or legislative matters" and stating that "[t]hese guidelines apply to psychiatrists practicing in a forensic role").

25 SPECIALTY GUIDELINES FOR FORENSIC PSYCHOLOGY app. B (AM. PSYCHOL. ASS'N 2011) [hereinafter APA SPECIALTY GUIDELINES].

26 *See* Appelbaum, *A Theory of Ethics*, *supra* note 15, at 239. Forensic mental health evaluations are typically conducted by professional psychiatrists and psychologists. *See* HEILBRUN, *supra* note 21, at 3. These mental health professionals are, of course, governed by different professional rules, standards, and ethical codes, though the process of forensic assessment is not typically defined by the profession of the evaluator. *Id.* at 6. Instead, "'the nature of the legal question' has served as the unifying theme and the focus of most of the literature in forensic assessment." *Id.* Although this Article focuses on both forensic psychiatrists and psychologists, many times the responsibilities and ethical concerns will relate to both types of mental health providers when they testify as forensic experts. For that reason, this Article will use the terms "clinician" or "mental health professional" to encompass both psychiatrists and psychologists, and use the individual terms when applicable.

competent to stand trial or criminally culpable for a charged offense, or whether a respondent meets civil commitment criteria. Often, a neutral psychiatrist or psychologist, one with no previous relationship to the evaluee, is retained to conduct an evaluation and provide testimony in a court proceeding. In some cases, however, when an individual clinician assumes both a treatment and a forensic role in the context of a single case, a dual-role relationship is created.[27]

Dual relationships between clinicians and patients in the forensic context can arise for a variety of reasons.[28] In the civil setting, if a patient already has a therapist and later becomes involved in litigation, the patient may prefer to have her original therapist testify and avoid the expense and inconvenience of visiting a separate mental health professional.[29] Some patients may also prefer not to share personal information with a new clinician when they have already shared the information with their existing therapist. If the therapist does not typically serve in a forensic role, she may not be aware of the conflict or the ethical guidelines advising against it, and may simply be trying to assist her patient. Similarly, attorneys may not be aware of the conflict dual relationships create and may send a client to the same clinician for both treatment and evaluation.[30] In the criminal setting, dual relationships often occur in criminal competency proceedings, especially in public hospitals where the same staff often perform both a

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27 *See* HEILBRUN, *supra* note 21, at 65.

28 *See* Larry H. Strasburger et al., *On Wearing Two Hats: Role Conflict in Serving as Both Psychotherapist and Expert Witness*, 154 AM. J. PSYCHIATRY 448, 448–49 (1997); *see also* HEILBRUN, *supra* note 21, at 65–66. As Heilbrun explains, dual roles occur in three types of circumstances. The first circumstance "involves the combination of a professional role (e.g., therapist, consultant, or forensic evaluator) with a personal or vocational role (e.g., spouse, lover, family member, friend, co-worker, or business associate)." *Id.* at 65. The second type occurs when "both roles are professional, most often a treatment role combined with a forensic evaluator role (e.g., a therapist serving as a forensic expert for a current therapy client)." *Id.* The last type of circumstance in which a dual relationship is created is when a forensic expert assumes "a second role within a forensic case (e.g., consultant), either concurrent with the role of forensic evaluator or after it has been completed." *Id.* at 66.

29 Of course, treatment and forensic roles can also become combined when a forensic evaluator later develops a therapeutic relationship with an evaluee. Although this Article does not specifically address that scenario, it is important to note that this type of relationship may also be vulnerable to bias stemming from the blurring of these two roles.

30 *See* Strasburger et al., *supra* note 28, at 449 ("Attorneys may believe that by enlisting the treating clinician as a forensic expert, they are making efficient use of the most knowledgeable source of information. After all, who is closer to the patient than his or her own therapist?"); *see also* THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF FORENSIC PSYCHIATRY 128–29 (Robert I. Simon & Liza H. Gold eds., 2d ed. 2010) ("Attorneys and even judges often believe that the treating psychiatrist . . . . has spent the most time with the individual and would therefore be expected to 'best' understand why the defendant acted as he or she did. However, this [mistaken] assumption contains many fallacies of which legal professionals are typically unaware.").

therapeutic and forensic role.[31] Finally, many parts of the country lack enough mental health professionals to perform separate forensic and clinical roles for every patient.[32]

This Article does not suggest that dual relationships are inappropriate or harmful in all circumstances. For instance, in small communities where few mental health professionals are available, refusing to provide therapeutic services to an individual with whom the clinician has an existing social or professional relationship might deprive the community of needed mental health care and treatment.[33] There are also instances in which a treating clinician might appropriately provide information in a legal setting on behalf of a patient. In the context of social security benefits, for example, claimants are required to submit the opinion of a "treating source."[34] Refusing to provide such documentation of the patient's claim could result in a harm to the patient much greater than any potential harm based on a dual relationship. Although this type of conflict and resulting unreliable

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31 *See* APPELBAUM & GUTHEIL, *supra* note 20, at 236. As Dr. Appelbaum and Dr. Gutheil state:

> Criminal forensic evaluations are often performed on an inpatient basis in public mental health facilities. When this occurs, the facility is charged with the responsibility of conducting the evaluation and treating a psychotic, depressed, or otherwise disordered patient. When staff time is at a premium, as is commonly the case, there is a temptation to ask the treating clinician to serve also as evaluator, the assumption being that time will thereby be conserved; this is a problematic situation.

Id. Some state statutes implicitly encourage dual relationships by requiring that individuals be evaluated by forensic clinicians in a state-run facility. Maine, for example, requires that the "defendant be examined by the State Forensic Service for evaluation of the defendant's competency to proceed." ME. STAT. tit. 15, § 101-D(1)(A) (2013). Other states, however, discourage the practice. *See, e.g.*, 725 ILL. COMP. STAT. ANN. 5/104-13(a) (2006) ("No physician, clinical psychologist or psychiatrist employed by the Department of Human Services shall be ordered to perform, in his official capacity, an examination under this Section.").

32 *See* NAT'L ALL. ON MENTAL ILLNESS, WORKFORCE DEVELOPMENT POLICY BRIEF 1 (2011) ("Our nationwide shortage of mental health professionals significantly impacts access to needed mental health treatment and contributes to inadequate care and unsafe conditions."); Kathleen C. Thomas et al., *County-Level Estimates of Mental Health Professional Shortage in the United States*, 60 PSYCHIATRIC SERVICES 1323, 1323 (2009) ("The shortage of mental health professionals has been a persistent concern for decades.").

33 *See* Sharon M. Moleski & Mark S. Kiselica, *Dual Relationships: A Continuum Ranging from the Destructive to the Therapeutic*, 83 J. COUNSELING & DEV. 3, 7–8 (2005) ("Such behavior merely trades one ethical concern for another."). Moleski and Kiselica also cite to, as an example, certain Asian cultures in which it is appropriate to express gratitude by giving gifts, stating that "[w]hile Western-trained professionals may believe that accepting a gift would blur boundaries, a refusal of the gift may result in the client feeling insulted." *Id.* at 8.

34 20 C.F.R. § 404.1527(c)(2) (2015) ("Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations.").

testimony can arise in a variety of litigation settings, this Article limits its analysis to forensic evaluations that occur in civil commitment and criminal competency evaluations. In these settings, where a clinician gives expert testimony on behalf of an individual with whom she has a preexisting therapeutic relationship, the court, the parties, and the patient are all affected by the conflict and resulting biased testimony.[35]

States vary widely in their requirements pertaining to forensic testimony in civil commitment and criminal competency proceedings. In civil commitment proceedings, many states require that a treating mental health professional conduct commitment evaluations when an individual is being held at a state facility,[36] while others permit a dual treating and forensic relationship.[37] Finally, a few states expressly prohibit this type of dual relationship in civil commitment proceedings.[38] In criminal competency proceedings, most states require that evaluations be conducted by a psychiatrist or psychologist, and a few states require that evaluations be performed by a "qualified" psychologist or psychiatrist.[39] Very few of these states explicitly require an individual who is not otherwise involved in the defendant's previous treatment or restoration to perform the competency evaluation.[40] A few state legislatures do seem to be aware of the potential ethical conflicts created by dual relationships and have prohibited dual relationships by statute. For example, Utah requires that competency evaluations be performed by "at least two mental health experts not involved in the current treatment of the defendant,"[41] while Indiana requires competent and disinterested evaluators, none of whom "may be an employee or a contractor of a state institution."[42]

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35 *See infra* Part II.

36 *See, e.g.*, COLO. REV. STAT. § 27-65-108 (2016) ("If the professional person in charge of the evaluation and treatment believes that a period longer than three months is necessary for treatment of the respondent, he or she shall file with the court an extended certification.").

37 *See, e.g.*, IND. CODE § 12-26-6-8(d) (2015) ("The physician who [evaluates an individual] may be affiliated with the community mental health center that submits to the court the report . . . .").

38 *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-498(c)(1) (2012) ("The court shall require the certificates, signed under penalty of false statement, of at least two impartial physicians selected by the court, one of whom shall be a practicing psychiatrist . . . and shall not be connected with the hospital for psychiatric disabilities to which the application is being made . . . .").

39 *See* Douglas Mossman et al., *AAPL Practice Guideline for the Forensic Psychiatric Evaluation of Competence to Stand Trial*, 35 J. AM. ACAD. PSYCHIATRY & L. (SUPPLEMENT) S3, S59–67 tbl.3 (2007).

40 *Id.*

41 UTAH CODE ANN. § 77-15-5(2)(b) (West 2004).

42 IND. CODE ANN. § 35-36-3-1 (2012). The Indiana statutes provides that:

> The court shall appoint two (2) or three (3) competent, disinterested: (1) psychiatrists; (2) psychologists endorsed by the Indiana state board of examiners in psychology as health service providers in psychology; or (3) physicians; who have expertise in determining competency. At least one (1) of the individuals appointed

Despite some statutory guidance regarding forensic mental health testimony, it is the judge who ultimately decides whether offered testimony is admissible.[43] As discussed in the following Section, while the mental health community has reached a consensus that testimony based on dual relationships is unethical and unreliable, most courts have not followed the view of the mental health community when ruling on the admissibility of this evidence.

A. *The Medical Ethical Guidelines*

In order to understand the propriety of forensic mental health testimony, it is useful to first consider the way in which mental health professionals view forensic mental health testimony and the limits that the mental health profession puts on such testimony. In their capacity as health care providers, mental health practitioners are, of course, bound by medical ethics. The overarching guideline of medical ethics is avoiding harm, with "the traditional Hippocratic moral obligation of medicine [being] to provide net medical benefit to patients with minimal harm—that is, beneficence with non-maleficence." [44] Beneficence obligates the clinician to "promote that which is beneficial to the patient," while non-maleficence requires that the clinician "do no harm."[45] It is from these moral principles that professional mental health associations create ethical standards and guidelines, with "their purpose being to establish relatively clear expectations for professional behavior."[46]

Because dual relationships can cause harm to patients and create conflicts of interest, psychiatrists and psychologists are generally advised to avoid relationships with patients outside of the therapeutic relationship.[47] While sexual relationships are often highlighted in ethical codes and the professional literature, "virtually all non-sexual dual

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> under this subsection must be a psychiatrist or psychologist. However, none may be an employee or a contractor of a state institution . . . .

Id.; *see also* N.C. GEN. STAT. § 15A-1002(b)(1a) (2016) ("In the case of a defendant charged with a misdemeanor or felony, the court may appoint one or more impartial medical experts . . . .").

43 *See infra* Section I.B.

44 Raanan Gillon, *Medical Ethics: Four Principles Plus Attention to Scope*, 309 BRIT. MED. J. 184, 185 (1994).

45 SHANE S. BUSH ET AL., ETHICAL PRACTICE IN FORENSIC PSYCHOLOGY: A SYSTEMATIC MODEL FOR DECISION MAKING 17 (2006).

46 Moleski & Kiselica, *supra* note 33, at 4.

47 *See id.*

relationships and conflicts of interest are [also] considered unethical."[48] This includes entering into a therapeutic relationship with a close friend or relative, socializing with patients, trading therapeutic services for other goods, and accepting gifts from patients.[49] Despite these long-standing prohibitions, Dr. Stone's 1982 speech is widely believed to be one of the first times anyone had publicly questioned the propriety of dual clinical and forensic roles in psychiatry.[50]

Dr. Stone believed that the forensic psychiatrist could not escape acting as a "double agent" because he could not combine the traditional clinical goal of doing no harm with the tasks required of forensic experts: truthful testimony and serving the interests of justice.[51] In his example of the sergeant, of course, Dr. Stone was serving, at least ostensibly, in a single forensic role. Yet, through the course of that forensic assessment, he learned personal details about the sergeant and felt that he had begun to develop a treating relationship with the sergeant.[52] For that reason, he questioned whether psychiatrists should give forensic testimony under any circumstances and explained that he himself no longer gave forensic testimony.[53] He ended his speech by concluding that the ethics of forensic psychiatry were in chaos and that the ethical foundations of the field were so inadequate that "forensic psychiatrists are necessarily engaged in a morally dubious enterprise."[54]

In the audience that day was a psychiatrist and former student of Dr. Stone's, Dr. Paul Appelbaum. Dr. Appelbaum objected to Dr. Stone's position that "there were no neutral principles of ethics by which forensic psychiatrists might guide their practices—and that none would be found," and concluded that Dr. Stone's position condemned forensic

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48 Vincent J. Rinella, Jr. & Alvin I. Gerstein, *The Development of Dual Relationships: Power and Professional Responsibility*, 17 INT'L J.L. PSYCHIATRY 225, 226 (1994).

49 *Id.*

50 See Appelbaum, *Ethics and Forensic Psychiatry, supra* note 17, at 196 ("Stone's talk was a turning point for the field, forcing it to confront directly its significant ethics challenges and the need for a coherent ethics framework to guide its work.").

51 *See* Stone, *The Ethical Boundaries of Forensic Psychiatry*, *supra* note 15, at 167–68, 170 (noting that he is "not a forensic psychiatrist. What has kept [him] out of the courtroom is [his] concern about the ethical boundaries of forensic psychiatry"). As Stone notes, "[t]he difference that makes a difference between clinical practice and forensic practice sometimes has been discussed under the heading of the psychiatrist as a double agent." *Id.* at 170.

52 *Id.* at 170 ("It is no accident that good clinicians often are emotionally seductive human beings inspiring personal trust.").

53 *Id.* at 167. Of course, one also needs to consider the potential harm should psychiatrists never offer forensic testimony. For example, in many cases, this might be a criminal defendant's primary means of offering mitigating evidence at trial or sentencing. According to Dr. Appelbaum, Dr. Stone has since clarified that "he never meant to suggest that psychiatrists should abandon the courtroom, [although] his view remains that psychiatry has nothing that it can offer the courts that is both truthful and of use to the legal process." Appelbaum, *Ethics and Forensic Psychiatry*, *supra* note 17, at 199.

54 Appelbaum, *Ethics and Forensic Psychiatry, supra* note 17, at 199.

psychiatrists "to wander in an ethical wasteland, permanently bereft of moral legitimacy."[55] Instead, Dr. Appelbaum proposed what has since become known as the "Standard Position," the view that psychiatrists are guided by different ethical principles when they are acting in clinical and forensic roles.[56] While the traditional ethical principles of beneficence and non-maleficence guide the psychiatrist in a clinical setting, "they do not attain primacy for the forensic psychiatrist."[57] When psychiatrists are performing a forensic role, we can therefore expect that they are capable of satisfying different ethical obligations.[58]

In developing an ethical framework for forensic psychiatry, Dr. Appelbaum identified ethical principles for forensic psychiatrists that differ from the traditional medical ethical obligations of beneficence and non-maleficence. First, the principle of "truth-telling" is based on the witnesses' oath to testify truthfully.[59] As Dr. Appelbaum notes, "[t]he primary task of the psychiatrist in the courtroom is to present the truth, insofar as that goal can be approached, from both a subjective and an objective point of view."[60] Subjective truth-telling means testifying honestly, while objective truth-telling means acknowledging, "insofar as possible, the limitations on his or her testimony, including those due to the limits of scientific or professional knowledge, as well as those specific to a particular case."[61] The second ethical principle Dr. Appelbaum identifies is "respect for persons."[62] In the forensic setting, this primarily means "undercut[ting] subjects' beliefs that they, acting in the usual way that physicians act, are placing subjects' interests above all other considerations."[63] Specifically, forensic psychiatrists should ensure

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55 *Id.* at 196 (quoting Appelbaum, *A Theory of Ethics*, *supra* note 15, at 234).

56 *See* Appelbaum, *Ethics and Forensic Psychiatry*, *supra* note 17, at 196–97.

57 Paul S. Appelbaum, *The Parable of the Forensic Scientist: Ethics and the Problem of Doing Harm*, 13 INT'L J.L. & PSYCHIATRY 249, 252 (1990). As Dr. Appelbaum notes, the principles of beneficence and non-maleficence are actually in conflict with the goals of forensic evaluation and testimony and "[t]he possibility that a result harmful to the evaluee might flow from the evaluation is the very feature that endows it with value." *Id.*

58 *See* Appelbaum, *A Theory of Ethics*, *supra* note 15, at 238. Dr. Appelbaum uses the example of a physician who works in both a clinical setting and a research setting. Dr. Appelbaum states that, while working in the clinical setting, "fidelity to patients' interests (that is beneficence and nonmaleficence) is the over-riding moral imperative." *Id.* When the physician goes to work in a research unit, on the other hand, "the advancement of knowledge, rather than the pursuit of health, takes priority. There is no reason to be uncomfortable with the notion that as one's role changes, so also do the ethics to which one is committed." *Id.*

59 *Id.* at 240.

60 *Id.* (alteration in original) (quoting Paul S. Appelbaum, *Psychiatric Ethics in the Courtroom*, BULL. AM. ACAD. PSYCHIATRY & L. 225, 225 (1984)).

61 *Id.*

62 *Id.*

63 *Id.* at 241. As Dr. Appelbaum notes, one risk of forensic psychiatry generally is that patients may not understand that the psychiatrist is acting in an evaluative role, and may instead assume that the psychiatrist is acting in a therapeutic role. *Id.* They may reason that

that the subject knows who the psychiatrist is, what role they play in the litigation, and that they are not serving a therapeutic function for the subject.[64]

At the same time that Dr. Appelbaum was developing his theory of the ethical practice of forensic psychiatry, AAPL created its own guidelines.[65] With respect to psychiatric forensic testimony, there is no outright prohibition against dual relationships in the ethical guidelines for psychiatrists. However, psychiatrists are advised to "generally avoid acting as an expert witness for their patients or performing evaluations of their patients for legal purposes."[66] Moreover, the Code of Ethics of the American Medical Association, which also governs psychiatrists, notes that physicians have "an [ethical] obligation to assist in the administration of justice," [67] but cautions that when a treating physician's testimony would adversely impact a patient's medical interests, the physician should not testify unless the patient consents or the physician is ordered to testify by the court.[68] When used as expert testimony in a legal proceeding, physician testimony "should reflect current scientific thought and standards of care that have gained acceptance among peers in the relevant field."[69]

Similarly, psychologists are warned that "[p]roviding forensic and therapeutic psychological services to the same individual or closely related individuals involves multiple relationships that may impair objectivity and/or cause exploitation or other harm" and are advised to "make reasonable efforts to refer the request to another qualified provider." [70] The American Psychological Association's Ethics Code more generally emphasizes "the goal of assisting without harming those

"[t]his person is a physician . . . . Surely she is here to help me, and at least will do me no harm. I am safe in speaking freely about whatever I choose." *Id.*

64 *Id.* Dr. Appelbaum also emphasizes the importance of maintaining confidentiality, noting that "[r]espect for persons also underlies the adherence of forensic psychiatrists to maintaining the confidentiality of the evaluation, except to the extent that disclosure is necessary to fulfill the forensic function." *Id.* at 242.

65 *See* AAPL FORENSIC PSYCHIATRY ETHICS GUIDELINES, *supra* note 24; *see also* HEILBRUN, *supra* note 21, at 68.

66 AAPL FORENSIC PSYCHIATRY ETHICS GUIDELINES § IV cmt., *supra* note 24.

67 AM. MED. ASS'N, AMA CODE OF MEDICAL ETHICS OP. 9.07 (2004) ("In various legal and administrative proceedings, medical evidence is critical. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.").

68 *Id.* ("When treating physicians are called upon to testify in matters that could adversely impact their patients' medical interests, they should decline to testify unless the patient consents or unless ordered to do so by legally constituted authority. If, as a result of legal proceedings, the patient and the physician are placed in adversarial positions it may be appropriate for a treating physician to transfer the care of the patient to another physician.").

69 *Id.*

70 APA SPECIALTY GUIDELINES, *supra* note 25, § 4.02.01.

with whom psychologists work."[71] Finally, General Principle D—Justice—was added to the Ethics Code in 2002 and obligates psychologists to "exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices."[72] Significantly, the APA Ethics Code attempts to reconcile conflicts between the requirements of the Code and related legal rules in the application section. The Code notes that:

> If this Ethics Code establishes a higher standard of conduct than is required by law, psychologists must meet the higher ethical standard. If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to this Ethics Code and take steps to resolve the conflict in a responsible manner in keeping with basic principles of human rights.[73]

Like psychiatry and psychology, many other professions have ethical guidelines that address dual relationships. Model Rule of Professional Conduct 1.8, for example, places restrictions on attorneys who enter into a business transaction with an existing client,[74] and prohibits attorneys from beginning a sexual relationship with an existing client.[75] This rule is meant to prevent attorneys from engaging in both a professional and personal relationship with a client. In the case of a clinician who both treats a patient and provides testimony about such patient in a legal proceeding, however, the resulting conflict is not between personal and professional roles, but between two distinct professional roles: that of a medical caregiver, and that of an expert legal witness.[76] The conflicts that can result from this type of dual

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71 BUSH ET AL., *supra* note 45, at 19.

72 ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT princ. D (AM. PSYCHOL. ASS'N 2010) [hereinafter APA GENERAL PRINCIPLES]. For a general description of the APA Ethics Code, see BUSH ET AL., *supra* note 45, at 19–20.

73 APA GENERAL PRINCIPLES, *supra* note 72, intro.

74 MODEL RULES OF PROF'L CONDUCT r. 1.8(a) (AM. BAR ASS'N 1983) ("A lawyer shall not enter into a business transaction with a client or knowingly acquire an ownership, possessory, security or other pecuniary interest adverse to a client unless: (1) the transaction and terms on which the lawyer acquires the interest are fair and reasonable to the client and are fully disclosed and transmitted in writing in a manner that can be reasonably understood by the client; (2) the client is advised in writing of the desirability of seeking and is given a reasonable opportunity to seek the advice of independent legal counsel on the transaction; and (3) the client gives informed consent, in a writing signed by the client, to the essential terms of the transaction and the lawyer's role in the transaction, including whether the lawyer is representing the client in the transaction.").

75 *Id.* at 1.8(j) ("A lawyer shall not have sexual relations with a client unless a consensual sexual relationship existed between them when the client-lawyer relationship commenced.").

76 *See* Strasburger et al., *supra* note 28, at 448–49.

relationship are therefore irreconcilable given the distinct goals and obligations of clinical and forensic patient relationships.

Because of the conflicts that can arise from dual relationships, psychiatrists and psychologists are urged by various ethical codes and regulations to avoid dual clinical and forensic relationships, and "[t]he professional literature provides reasonable support for not blending the roles of therapeutic and forensic clinician in the same case."[77] Many in the psychiatric community support this position, including Dr. Appelbaum, who believes that psychiatrists should not act simultaneously in both a clinical and forensic role, and refers to the AAPL guidelines that discourage this practice.[78] Specifically, Dr. Appelbaum notes that the information a psychiatrist gathers during the course of treatment should be used only to benefit the patient, and even if the psychiatrist is well intentioned, using the same information in a forensic setting "may redound to the patient's detriment."[79] Other commentators are less subtle and propose "a rule imposing a clear, impenetrable boundary between therapeutic and forensic roles within a single case."[80]

The ethical guidelines for both psychiatrists and psychologists are therefore consistent in warning against dual relationships created when a single clinician assumes both a therapeutic and clinical role. Furthermore, while there is some diversity among mental health professionals as to whether such relationships should be avoided entirely, "the majority of the literature is inclined against blending

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77 HEILBRUN, *supra* note 21, at 69.

78 *See* Paul S. Appelbaum, Editorial, *Ethics in Evolution: The Incompatibility of Clinical and Forensic Functions*, 154 AM. J. PSYCHIATRY 445, 445 (1997) [hereinafter Appelbaum, *Ethics in Evolution*]. Appelbaum cites to the Ethical Guidelines for the Practice of Forensic Psychiatry of the American Academy of Psychiatry and the Law, *see* AAPL FORENSIC PSYCHIATRY ETHICS GUIDELINES, *supra* note 24, which discourage a single psychiatrist from performing both a clinical and forensic role, and notes the "fundamental incompatibility between the ethics of the two situations." Appelbaum, *Ethics in Evolution*, *supra*; *see also* APPELBAUM & GUTHEIL, *supra* note 20, at 237 (noting that role separation is optimal because of conflicts of interest that arise from dual relationships).

79 Appelbaum, *Ethics in Evolution*, *supra* note 78, at 446.

80 Daniel W. Shuman et al., Special Perspective, *An Immodest Proposal: Should Treating Mental Health Professionals Be Barred from Testifying About Their Patients?*, 16 BEHAV. SCI. L. 509, 514 (1998). As the authors note:

> Under such a rule, across the judicial spectrum, therapists would not be permitted to testify about their patients even if the parties or the court requested it. Instead, only forensic examiners who had not treated the patient/litigant and, ideally, who had specialized forensic training, could appear as retained or appointed experts. Apart from avoiding the harm that proscription of therapeutic/forensic role conflicts is designed to avoid, there are several reasons why such a proposal may be appealing for therapy and the provision of information in the courtroom.

Id.; *see also* BUSH ET AL., *supra* note 45, at 14 ("In general, to maximize objectivity, these roles should not be combined in a single case.").

personal–professional or therapeutic–forensic roles in a single case. There is sufficient support to conclude that this principle is *established*."[81]

B. *The Legal Guidelines*

Notwithstanding the ethical prohibitions and extensive commentary within the psychiatric and psychological fields, the legal system, which relies heavily on forensic psychiatric and psychological testimony, offers almost no guidance on the propriety of dual relationships. Dr. Kirk Heilbrun, in a review of legal standards governing the practice, notes simply that "[n]o legal authority on this principle was located."[82] Notwithstanding the lack of governing case law, forensic mental health testimony—like all expert testimony—is governed by the rules of evidence, which provide some guidance as to the propriety of clinicians who offer testimony in a case in which they have a dual relationship with a patient.

Under the Federal Rules of Evidence (FRE or Rules), mental health professionals may testify as either lay witnesses or expert witnesses. FRE 701 allows lay witnesses to give an opinion about matters that are "rationally based on the witness's perception," helpful to the jury, and "not based on scientific, technical, or other specialized knowledge."[83] If a clinician testifies about things she simply observed or witnessed while meeting with a patient, she would be considered a lay witness under FRE 701.[84] In contrast, when the clinician expresses a professional

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81 HEILBRUN, *supra* note 21, at 73.

82 *Id.* at 68. One exception to this lack of guidance can be found in the American Bar Association's "black letter" standards that govern issues of mental health in criminal law proceedings. *See* CRIMINAL JUSTICE MENTAL HEALTH STANDARDS (AM. BAR ASS'N 1988), http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_mentalhealth_blk.html. Specifically, Standard 7-3.11 governs the qualifications for expert witnesses who testify about a person's mental condition. *See id.* § 7-3.11(a)(ii)(B) (noting that experts may gain sufficient knowledge to testify in a case based on "a professional therapeutic or habilitative relationship with the person whose mental condition is in question").

83 FED. R. EVID. 701. The rule governs lay witness testimony and provides:

> If a witness is not testifying as an expert, testimony in the form of an opinion is limited to one that is: (a) rationally based on the witness's perception; (b) helpful to clearly understanding the witness's testimony or to determining a fact in issue; and (c) not based on scientific, technical, or other specialized knowledge within the scope of Rule 702.

Id.

84 The doctor-patient privilege would of course limit the clinician's ability to give this testimony, but a patient can choose to waive that privilege. *See, e.g.*, Clay v. Woodbury Cty., 965 F. Supp. 2d 1055, 1060 (N.D. Iowa 2013) ("Under Iowa law, the physician-patient privilege 'may be waived by the defendant's disclosure or consent to disclosure of the privileged information.'" (quoting State v. Demaray, 704 N.W.2d 60, 65 (Iowa 2005))).

opinion about those facts based on her "knowledge, skill, experience, training, or education," she becomes an expert witness and is subject to the more stringent requirements of FRE 702.[85]

For much of the twentieth century, the major case governing the admissibility of expert testimony was *Frye v. United States*, which provided what became known as the "general acceptance" test.[86] In *Frye*, the defendant attempted to prove his innocence by introducing expert testimony about the results of a lie detector test that measured systolic blood pressure.[87] In rejecting this testimony, the court created the standard for the introduction of expert testimony, holding that the point at which a scientific theory or principle should form the basis of expert testimony is difficult to pinpoint, but that:

> Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs.[88]

Frye's general acceptance standard proved problematic for new and contested scientific areas. For example, under *Frye*, defendants were unable to introduce expert testimony about now commonly accepted conditions such as pathological gambling,[89] and battered woman

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85 FED. R. EVID. 702. The rule governs expert witness testimony and provides:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case.

Id.

86 *See* Frye v. United States, 293 F. 1013 (D.C. Cir. 1923). Though the Supreme Court later announced a new standard applicable to the federal courts in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), many states have rejected the *Daubert* test and continue to use the *Frye* standard to determine the admissibility of expert testimony. *See, e.g.*, N.Y. C.P.L.R. 4515 (MCKINNEY 2015); PA. R. EVID. 702.

87 *See Frye*, 293 F. at 1013–14. The court describes the lie detector test as one that can purportedly measure systolic blood pressure, which is raised by "conscious deception or falsehood, concealment of facts, or guilt of crime, accompanied by fear of detection when the person is under examination." *Id.* at 1013. Systolic blood pressure, in turn "corresponds exactly to the struggle going on in the subject's mind, between fear and attempted control of that fear, as the examination touches the vital points in respect of which he is attempting to deceive the examiner." *Id.* at 1013–14.

88 *Id.* at 1014.

89 *See, e.g.*, United States v. Lewellyn, 723 F.2d 615 (8th Cir. 1983). In a trial for embezzlement, the court held that to enter an insanity plea, Lewellyn was required to demonstrate "that there is general acceptance in the fields of psychiatry and psychology of the

syndrome.[90] Many commentators criticized the *Frye* test for its inflexibility and inability to keep up with the rapid scientific developments.[91] And while the FRE, which were adopted in 1976, seemed to suggest that courts should take a more expansive view of the use of scientific expert testimony,[92] most federal circuits, and about half of the states, continued to apply *Frye*'s general acceptance rule to govern the admissibility of contested expert testimony.[93]

More than two decades after the adoption of the FRE, the United States Supreme Court clarified that the Rules, and not *Frye*'s general acceptance test, were the controlling standard for the admissibility of expert testimony in federal courts.[94] In *Daubert v. Merrell Dow*

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principle that some pathological gamblers lack substantial capacity to conform their conduct to the requirements of laws prohibiting embezzlement and similar offenses." *Id.* at 619. Because pathological gambling was not included in the current Diagnostic and Statistical Manual of Mental Disorders (DSM), and the expert did not testify that it was generally accepted by other mental health professionals, Lewellyn did not establish the "requisite indicia of scientific reliability." *Id.* at 620.

90 *See, e.g.*, State v. Thomas, 423 N.E.2d 137, 140 (Ohio 1981), *overruled by* State v. Koss, 551 N.E.2d 970 (Ohio 1990) (holding that "'battered wife syndrome' is not sufficiently developed, as a matter of commonly accepted scientific knowledge, to warrant testimony under the guise of expertise"). As MCCORMICK ON EVIDENCE notes,

> Polygraphy, graphology, hypnotic and drug induced testimony, voice stress analysis, voice spectrograms, various forms of spectroscopy, infrared sensing of aircraft, retesting of breath samples for alcohol content, psychological profiles of battered women and child abusers, post traumatic stress disorder as indicating rape, . . . astronomical calculations, . . . [and] blood group typing, . . . all have fallen prey to [*Frye*'s] influence.

MCCORMICK ON EVIDENCE § 203 (Kenneth S. Broun ed., 6th ed. 2006) (footnotes omitted).

91 *See, e.g.*, Andre A. Moenssens, *Admissibility of Scientific Evidence—An Alternative to the* Frye *Rule*, 25 WM. & MARY L. REV. 545, 547 (1984).

92 *See, e.g.*, FED. R. EVID. 702 (amended 2000, 2011). The 1972 Advisory Committee notes on the existing version of FRE Rule 702 provided:

> The rule is broadly phrased. The fields of knowledge which may be drawn upon are not limited merely to the "scientific" and "technical" but extend to all "specialized" knowledge. Similarly, the expert is viewed, not in a narrow sense, but as a person qualified by "knowledge, skill, experience, training or education." Thus within the scope of the rule are not only experts in the strictest sense of the word, e.g., physicians, physicists, and architects, but also the large group sometimes called "skilled" witnesses, such as bankers or landowners testifying to land values.

FED. R. EVID. 702 advisory committee's note to 1972 proposed rule.

93 *See* Michael J. Saks, *Merlin and Solomon: Lessons from the Law's Formative Encounters with Forensic Identification Science*, 49 HASTINGS L.J. 1069, 1076–77 (1998) (noting that while the FRE rejected *Frye* and instead focused on the validity of the proposed scientific testimony, "we did not learn this about the Federal Rules until the Supreme Court's unanimous decision in *Daubert v. Merrell Dow* in 1993").

94 *See* Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 586–87 (1993). The Court noted that while many had debated the merits of *Frye*'s general acceptance test, the "[p]etitioners' primary attack, however, is not on the content but on the continuing authority of the rule. They contend that the *Frye* test was superseded by the adoption of the Federal Rules of Evidence. We agree." *Id.* at 587 (footnote omitted).

Pharmaceuticals, Inc., Joyce Daubert was prescribed Bendectin for nausea during her pregnancy.[95] When her son, Jason, was later born with a malformed right arm, the Dauberts sued Merrell Dow, the manufacturer of Bendectin.[96] At trial, Merrell Dow's expert testified that, based on his extensive review of the scientific literature, "maternal use of Bendectin during the first trimester of pregnancy has not been shown to be a risk factor for human birth defects."[97]

In response, the Dauberts introduced the testimony of eight experts.[98] These experts did not disagree with Merrell Dow's expert regarding the published human studies, but instead concluded—based on animal-cell studies, live-animal studies, and chemical-structure analyses—that the drug can cause birth defects if administered during pregnancy.[99] In granting Merrell Dow's motion for summary judgment, the district court applied the *Frye* standard to the Dauberts' expert testimony, and concluded that the testimony did not meet the standard because the animal studies and chemical-structure analyses conducted by the Dauberts' experts were not generally accepted by the scientific community. [100] The Ninth Circuit affirmed the district court's decision.[101]

On appeal, the United States Supreme Court first noted that the "*Frye* test has its origin in a short and citation-free 1923 decision," and clarified that *Frye* was "superseded by the adoption of the Federal Rules

95 Daubert v. Merrell Dow Pharm., Inc., 711 F. Supp. 546, 547 (S.D. Cal. 1989).

96 Jason Daubert was born with two fingers on his right hand and without a lower bone on his right arm. *See* Natalie Angier, *High Court to Consider Rules on Use of Scientific Evidence*, N.Y. TIMES (Jan. 2, 1993), http://www.nytimes.com/1993/01/02/us/high-court-to-consider-rules-on-use-of-scientific-evidence.html; *see also Daubert*, 711 F. Supp. at 547 ("Jason was born with a limb-reduction defect of his arm and hand."). The Dauberts were joined in their lawsuit by another family, the Schullers, whose son Eric had suffered similar birth defects after his mother was prescribed Bendectin during pregnancy, being born without a left hand and with one leg shorter than the other. *See* Angier, *supra*.

97 *Daubert*, 509 U.S. at 582. The expert, Dr. Lamm, testified that he had reviewed more than thirty published studies involving more than 130,000 patients and that none of those studies had found that Bendectin caused birth defects. *Id.*

98 *Id.* at 583.

99 *Id.* The experts based their conclusions upon test tube and animal studies "that found a link between Bendectin and malformations," studies of the chemical structure of Bendectin that found its structure was similar to that of other substances that were known to cause birth defects, and a reanalysis of previously published human studies of Bendectin. *Id.*

100 Daubert v. Merrell Dow Pharm., Inc., 727 F. Supp. 570, 575 (S.D. Cal. 1989). As the district court noted, because "epidemiological studies are the most reliable evidence of causation in this area[,] . . . expert opinion which is not based on epidemiological evidence is not admissible to establish causation because it lacks the sufficient foundation necessary under FRE 703." *Id.* The district court also rejected the testimony regarding the reanalysis of the published human studies of Bendectin because it had not been published or subjected to peer review. *Id.*

101 *See* Daubert v. Merrell Dow Pharm., Inc., 951 F.2d 1128 (9th Cir. 1991).

of Evidence."[102] The Court observed that *Frye*'s requirement of general acceptance was "rigid" and "at odds with the 'liberal thrust' of the Federal Rules and their 'general approach of relaxing the traditional barriers to "opinion" testimony.'"[103] Instead, the Rules require that opinion evidence be both reliable and helpful to the fact finder.[104] Rule 702 itself was later amended to include this focus on helpfulness and reliability.[105]

Perhaps most significantly, the Court assigned the screening role, which under *Frye* had been primarily left to the experts themselves, to the trial judge.[106] The Court created a nonexhaustive list of factors for trial judges to consider in making this assessment, including whether the theory or technique has been tested, whether it has been subjected to peer review and publication, whether there is a known or potential rate of error, whether there are standards controlling the technique's operation, and finally, whether the technique has been generally accepted by the relevant scientific community.[107] While general acceptance is therefore no longer the only standard courts can consider in evaluating expert witness testimony, it still remains a factor the judge may consider. Moreover, it is the trial judge who is responsible for evaluating proposed expert testimony under Rule 702 to ensure that it is sufficiently helpful and reliable.

Notwithstanding the Supreme Court's confidence in the ability of trial judges to perform this screening function,[108] some lower court judges expressed concern about taking on this role. Writing on remand

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102 *Daubert*, 509 U.S. at 585, 587. The Court noted that the Rules' permissive nature, and the absence of the "general acceptance" language within the text of the revised FRE 702, made "the assertion that the Rules somehow assimilated *Frye* . . . unconvincing. *Frye* made 'general acceptance' the exclusive test for admitting expert scientific testimony. That austere standard, absent from, and incompatible with, the Federal Rules of Evidence, should not be applied in federal trials." *Id.* at 589.

103 *Id.* at 588 (quoting Beech Aircraft Corp. v. Rainey, 488 U.S. 153, 169 (1988)).

104 *Id.* at 590–91.

105 *See* FED. R. EVID. 702. The rule provides that:

> A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case.

Id.

106 *Daubert*, 509 U.S. at 589 ("[U]nder the Rules the trial judge must ensure that any and all scientific testimony or evidence admitted is not only relevant, but reliable.").

107 *Id.* at 593–94.

108 *Id.* at 593 ("We are confident that federal judges possess the capacity to undertake this review.").

in *Daubert*, for example, Judge Kozinski describes this "daunting" task as follows:

> Our responsibility, then, unless we badly misread the Supreme Court's opinion, is to resolve disputes among respected, well-credentialed scientists about matters squarely within their expertise, in areas where there is no scientific consensus as to what is and what is not "good science," and occasionally to reject such expert testimony because it was not "derived by the scientific method." Mindful of our position in the hierarchy of the federal judiciary, we take a deep breath and proceed with this heady task.[109]

Furthermore, while *Daubert* was meant to provide clarity about the standards and the role of the court in determining the admissibility of expert testimony, some commentators have observed that the Court "did not address anything at all."[110] Because *Frye*'s general acceptance test remained part of the broader inquiry under *Daubert*, many felt that *Daubert* could in fact be seen as a victory for either side.[111] Specifically, many courts and commentators were left wondering whether the new reliability standard set forth was intended to be more or less restrictive than *Frye*'s general acceptance test.[112] Notwithstanding the additional factors judges may consider under *Daubert*, however, it is clear that admission of forensic testimony "entails a preliminary assessment of whether the reasoning or methodology underlying the testimony is

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109 Daubert v. Merrell Dow Pharm., Inc., 43 F.3d 1311, 1316 (9th Cir. 1995); *see also* David L. Faigman, Essay, *Mapping the Labyrinth of Scientific Evidence*, 46 HASTINGS L.J. 555, 558 (1995) (questioning whether judges have the time and energy necessary to master complex scientific theories and observing that scientific testimony covers "topics ranging from voice spectrography to gas chromatography, from premenstrual syndrome to post-traumatic stress syndrome, and from identification through bitemarks to identification through handwriting" and that "[a] judge attempting to swim from shore to shore of this sea would finish, at best, exhausted and, at worst and more likely, drown").

110 Joseph B. Spero, Note, *Much Ado About Nothing—The Supreme Court Still Fails to Solve the General Acceptance Problem Regarding Expert Testimony and Scientific Evidence*, 8 J.L. & HEALTH 245, 268 (1993–94).

111 *See* Kenneth R. Foster et al., *Science and the Toxic Tort*, 261 SCI. 1509, 1614 (1993) ("Astonishingly, all parties expressed satisfaction with the *Daubert* decision—the lawyers for the plaintiff and defense, and scientists who wrote *amicus* briefs."). As one author put it at the time, "[t]his alone should have raised red flags." Paul C. Giannelli, *The Supreme Court's "Criminal"* Daubert *Cases*, 33 SETON HALL L. REV. 1071, 1077 (2003).

112 *See* Giannelli, *supra* note 111, at 1077. More recently, some studies have not found significant changes in the admission of expert testimony since *Daubert*. *See, e.g.*, Jennifer L. Groscup et al., *The Effects of* Daubert *on the Admissibility of Expert Testimony in State and Federal Criminal Cases*, 8 PSYCHOL. PUB. POL'Y & L. 339, 370 (2002). Although judges do seem to be embracing the gatekeeping role, it "is not necessarily accomplished by applying the suggested four *Daubert* criteria, but is instead accomplished by increased and differential application of the Rules to different types of testimony." *Id.*

scientifically valid."[113] It is the reliability of the methods that produced the testimony itself that therefore determines reliability.[114]

As the next Part will explore, however, when forensic mental health testimony is based on information obtained as a result of a dual relationship, that testimony does not meet the *Daubert* reliability threshold. In this circumstance, the methodology that produces the information violates controlling ethical guidelines, and the testimony itself is therefore unreliable under *Daubert* and Rule 702.

II. THE PROBLEM WITH DUAL RELATIONSHIPS

When a single clinician engages in both a treating and forensic role with an individual patient, a variety of harms can result. Testimony arising out of dual relationships causes harm to the patient by subjecting her to potentially negative legal outcomes, and to the therapeutic relationship by impairing the patient's trust in the therapist. Furthermore, this type of dual relationship creates a conflict of interest for the clinician. This conflict may render the clinician unable to eliminate bias from her judgment, bias that may ultimately make her an unreliable witness. Finally, disclosure of the conflict to the patient or evaluee is not enough to mitigate the resulting bias.

A. *Harm to the Patient: Agency, Rapport, and Empathy*

When a clinician provides forensic testimony in a case in which she is also treating the evaluee, the evaluee may, of course, suffer harm.[115]

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113 *Daubert*, 509 U.S. at 592–93.

114 *See* Daniel A. Krauss et al., *The Admissibility of Expert Testimony in the United States, the Commonwealth, and Elsewhere*, *in* 2 PSYCHOLOGICAL EXPERTISE IN COURT: PSYCHOLOGY IN THE COURTROOM 1, 8 (Daniel A. Krauss & Joel D. Lieberman eds., 2009) ("[W]hile the *Daubert* standard is commonly referred to as a reliability standard by legal commentators, it is actually meant to be an examination of the scientific validity of expert testimony."). The Supreme Court reaffirmed the judge's gatekeeping role in *Kumho Tire*, where it held that *Daubert* "applies not only to testimony based on 'scientific' knowledge, but also to testimony based on 'technical' and 'other specialized' knowledge." Kumho Tire Co. v. Carmichael, 526 U.S. 137, 141 (1999) (quoting FED. R. EVID. 702). Because *Daubert*'s list of factors is flexible, courts need not apply every factor to experts in each case and can instead determine how to measure reliability on a case-by-case basis. As Justice Breyer noted in the opinion in *Kumho Tire*, the line between scientific and other technical or specialized knowledge is unclear and "conceptual efforts to distinguish the two are unlikely to produce clear legal lines capable of application in particular cases." *Id.* at 148.

115 *See* BUSH ET AL., *supra* note 45, at 18 ("For forensic examinations, helping the examinee is not a primary goal of the examiner. Helping the trier of fact to make an appropriate determination taking into account the examinee's cognitive or psychological functioning is a goal. The examinee may or may not benefit from the examination findings.").

For instance, the clinician might testify that the evaluee is competent to stand trial for a crime and the evaluee could be subject to criminal punishment. Similarly, the clinician could testify that the evaluee meets the state's requirements for civil commitment and the evaluee could be subject to confinement and loss of liberty. This ethical conflict was the basis of Dr. Stone's argument that psychiatrists should never act as expert witnesses, because he felt that by giving any forensic testimony, they would always be violating the ethical maxims of beneficence and non-maleficence.[116]

Dr. Appelbaum attempted to reconcile these conflicting roles by noting that the clinician could fulfill her obligations to a patient in a therapeutic setting, while still fulfilling separate obligations to a court in a legal setting.[117] Yet Dr. Appelbaum never suggested that the same clinician attempt to fill both roles for the same patient.[118] When a clinician evaluates a patient for treatment purposes, she is seeking information that will assist her in helping her patient and she uses that information only with an awareness of her ethical obligation to act in the patient's best interest and avoid harm to the patient.[119] This obligation to act in the patient's best interest can be difficult or impossible to fulfill when a treating clinician testifies in a legal proceeding because in attempting to simultaneously give accurate and truthful testimony about the patient, she may persuade the fact finder to impose a variety of bad outcomes that harm the patient.[120]

In addition to the legal harms that can result from forensic testimony, when a clinician offers truthful forensic testimony about an existing patient, this testimony may cause significant impairment of the therapeutic relationship and a corresponding decline in the patient's trust in the therapist.[121] The therapeutic relationship—or the therapeutic alliance—between a patient and a psychiatrist is "the collaborative bond between therapist and patient [and] is widely considered to be an essential ingredient in the effectiveness of psychotherapy."[122] Indeed, the

116 *See supra* text accompanying notes 1–17.

117 *See supra* text accompanying notes 54–64.

118 *See* Appelbaum, *Ethics in Evolution*, *supra* note 78, at 445 ("[The] contemporary sentiment among forensic psychiatrists is accurately reflected in the *Ethical Guidelines for the Practice of Forensic Psychiatry* of the American Academy of Psychiatry and the Law, which discourage psychiatrists from simultaneously performing both clinical and forensic roles.").

119 *See supra* Section I.A.

120 *See generally* Stuart A. Greenberg & Daniel W. Shuman, *Irreconcilable Conflict Between Therapeutic and Forensic Roles*, 28 PROF. PSYCHOL. RES. & PRAC. 50 (1997).

121 *See* APPELBAUM & GUTHEIL, *supra* note 20, at 238 ("[T]he necessity for the clinician to reveal her opinions concerning the patient's diagnosis, functional state, and the like, as well as the possibility that the clinician's opinion will not be favorable to the patient/subject, are likely to interfere with subsequent therapy."); *see also* Greenberg & Shuman, supra note 120, at 56.

122 Janice L. Krupnick et al., *The Role of the Therapeutic Alliance in Psychotherapy and Pharmacotherapy Outcome: Findings in the National Institute of Mental Health Treatment of*

quality of this relationship is often more predictive of a successful therapeutic outcome than the specific therapeutic techniques the therapist uses with the patient.[123]

At the core of the therapeutic relationship are both rapport and empathy. Rapport between the client and therapist "depends on mutual respect and interest, expressed in words and behavior, between clinician and patient."[124] Empathy can be generally described as "the ability to understand the patient's situation, perspective, and feelings and to communicate that understanding to the patient."[125] When patients perceive that their therapist is empathetic, this can improve outcomes for patients, as well as create an environment in which patients are less defensive and more willing "to talk about their perceptions of need."[126] To develop a positive therapeutic relationship, the patient must feel understood by the therapist, and the therapist must suspend judgment of the patient.[127]

The impact of dual relationships on the therapeutic relationship arises in both outpatient and inpatient settings. When a clinician offers legal testimony about a patient with whom she has an existing outpatient relationship, the clinician must often reveal opinions about the patient's mental state. Because much of this testimony may be unfavorable to the patient, this testimony is likely to impair the therapeutic relationship and have an impact on any subsequent

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Depression Collaborative Research Program, 64 J. CONSULTING & CLINICAL PSYCHOL. 532, 532 (1996); *see also* Marvin R. Goldfried & Joanne Davila, *The Role of Relationship and Technique in Therapeutic Change*, 42 PSYCHOTHERAPY: THEORY RES. PRAC. TRAINING 421, 427 (2005) ("The establishment of an optimal therapeutic alliance is most certainly based on the quality of the therapy relationship, which particularly contributes to the formation of the bond between client and therapist."); Michael J. Lambert & Dean E. Barley, *Research Summary on the Therapeutic Relationship and Psychotherapy Outcome*, 38 PSYCHOTHERAPY 357, 359 (2001) (noting that in a review of more than 100 studies, the research has "consistently reported a positive relationship between the therapeutic alliance and outcome across studies").

123 *See* Fredrik Falkenström et al., *Therapeutic Alliance Predicts Symptomatic Improvement Session by Session*, 60 J. COUNSELING PSYCHOL. 317, 317 (2013); Lambert & Barley, *supra* note 122, at 359 ("[T]herapists need to remember that the development and maintenance of the therapeutic relationship is a primary curative component of therapy and that the relationship provides the context in which specific techniques exert their influence."); Dale A. Matthews et al., *Making "Connexions": Enhancing the Therapeutic Potential of Patient-Clinician Relationships*, 118 ANNALS INTERNAL MED. 973, 973 (1993) ("An important component of healing, apart from the effect of any technology that is applied, derives from the relationship between the healer and the patient.").

124 Matthews et al., *supra* note 123, at 974.

125 John L. Coulehan et al., *"Let Me See if I Have this Right . . . ": Words that Help Build Empathy*, 135 ANNALS INTERNAL MED. 221, 221 (2001).

126 Stewart W. Mercer & William J. Reynolds, *Empathy and Quality of Care*, 52 BRIT. J. GEN. PRAC. (SUPPLEMENT) S9, S9 (2002); *see also* Coulehan et al., *supra* note 125, at 221 ("The effective use of empathy promotes diagnostic accuracy, therapeutic adherence, and patient satisfaction, while remaining time-efficient.").

127 *See* Greenberg & Shuman, *supra* note 120, at 54.

therapy.[128] The clinician can attempt to repair the relationship and resume treatment, but "[i]f the alliance cannot be repaired, termination and referral may be necessary."[129] Furthermore, patients who are aware that the information they disclose to a therapist might be later used in a legal proceeding are much more likely to self-censor and withhold damaging information from the therapist.[130] This lack of disclosure could also have a negative impact on the patient's further treatment.[131]

In the inpatient context, where the staff at public mental health facilities is often responsible for both treatment and criminal forensic evaluations, "there is a temptation to ask the treating clinician to serve also as evaluator, the assumption being that time will thereby be conserved."[132] Yet for the newly hospitalized defendant, who is asked to confide in a clinician for treatment purposes, and also asked to disclose information to the same clinician for evaluation purposes, this can present an irreconcilable problem. The defendant must confide in the clinician to receive appropriate treatment, yet is also told that anything she tells the clinician during an inpatient evaluation may be used against her in court.[133] A defendant who chooses to withhold information during treatment because she feels it might be used against her later could be seen as uncooperative or malingering.[134] Therefore, even if the defendant is able to distinguish between the clinician's two roles, "there may be no way for her to resolve the conflicting messages the clinician conveys concerning the desirability of disclosure."[135] Moreover, dual relationships in the criminal setting can adversely affect the treatment received by a defendant who is charged with a serious crime.[136]

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128 *See* APPELBAUM & GUTHEIL, *supra* note 20, at 237–38.

129 *Id.* at 238.

130 *See* Greenberg & Shuman, *supra* note 120, at 56.

131 *See id.*

132 APPELBAUM & GUTHEIL, *supra* note 20, at 236. In the inpatient forensic setting, the conflict of interest is less troubling when the primary form of treatment has a strictly restorative focus. If the patient is involved in group therapy and focused on learning about legal procedures, a therapist involved in that group therapy may also appropriately act as a forensic evaluator.

133 Appelbaum, *A Theory of Ethics*, *supra* note 15, at 241 ("Forensic psychiatrists, . . . must make clear to the subjects of their evaluations who they are, what role they are playing in the case (including which side they are working for), the limits on confidentiality, and—of particular importance—that they are not serving a treatment function.").

134 Malingering assessments often direct clinicians to suspect malingering when the evaluee demonstrates substantial noncompliance with treatment, or "inadequate and/or variable levels of effort on standard psychological tests." THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF FORENSIC PSYCHIATRY, *supra* note 30, at 469, 473; *see also* Thomas M. Dunn et al., *Detecting Neuropsychological Malingering: Effects of Coaching and Information*, 18 ARCHIVES CLINICAL NEUROPSYCHOLOGY 121, 121 (2003) ("Accurate assessment . . . is dependent upon the patient putting forth his or her best possible effort.").

135 APPELBAUM & GUTHEIL, *supra* note 20, at 237.

136 *Id.*

Inexperienced staff members who believe a criminal defendant is unlike other inpatient psychiatric patients may engage her in less treatment or adopt a "hands off policy towards [her]."[137]

B. *Harm to the Legal System: Bias and Unreliability*

In addition to causing harm to the patient and the therapeutic relationship, dual forensic and clinical relationships can exacerbate bias and contribute to unreliable expert testimony. One striking example of biased expert testimony can be seen in the 2004 case of Brandon Mayfield. Mayfield was an attorney in Oregon who was arrested in Portland for his alleged role in the bombings of four commuter trains in Madrid on March 11, 2004, which killed 191 people and wounded more than 1,800.[138] According to the FBI, Mayfield's fingerprint was found on a plastic bag at the scene of the bombing, but the FBI's fingerprint analysis turned out to be incorrect and Mayfield was later released.[139] Mayfield, a Muslim, claimed to have been targeted based on his faith, but the United States Department of Justice (DOJ) denied that accusation and instead released a statement claiming that while it had used "standard protocols and methodologies . . . [u]pon review it was determined that the FBI identification was based on an image of substandard quality."[140]

Mayfield's case gained the attention of civil rights leaders who argue that the Patriot Act "has made it too easy for law enforcement to spy on people."[141] Others have criticized the FBI for a more technical reason: its analysis of the forensic fingerprint evidence.[142] In its review of the case, the DOJ outlined several reasons for the misidentification, among them the unusual similarity between Mayfield's prints and the

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137 *Id.* ("When a patient is accused of a dramatic, violent, perverse, or unusual crime, clinical staff may react to or recoil from the patient . . . as if she were already found guilty. . . . Thus, 'preconviction' may deprive the patients of careful attention and objective assessment of their actual state.").

138 *See* Dan Eggen, *U.S. Settles Suit Filed by Ore. Lawyer*, WASH. POST (Nov. 30, 2006), http://www.washingtonpost.com/wp-dyn/content/article/2006/11/29/AR2006112901179.html; *see also Spain Train Bombing Fast Facts*, CNN (Mar. 4, 2016, 11:39 AM), http://www.cnn.com/2013/11/04/world/europe/spain-train-bombings-fast-facts.

139 *See* Eggen, *supra* note 138. Mayfield eventually settled with the FBI for two million dollars and a written apology. *Id.*

140 Press Release, Fed. Bureau of Investigation, Statement on Brandon Mayfield Case (May 24, 2004), http://www.fbi.gov/news/pressrel/press-releases/statement-on-brandon-mayfield-case.

141 Larry Abramson, *The Patriot Act: Alleged Abuses of the Law*, NAT'L PUB. RADIO (July 20, 2005, 12:00 AM), http://www.npr.org/templates/story/story.php?storyId=4756403.

142 OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF JUSTICE, A REVIEW OF THE FBI'S HANDLING OF THE BRANDON MAYFIELD CASE 6–9 (2006) [hereinafter FBI'S HANDLING OF THE MAYFIELD CASE].

prints found at the scene, the poor quality of the fingerprint image, and faulty reliance on "tiny details."[143]

In addition to these causes, however, the DOJ also identified the existence of bias among the fingerprint examiners, specifically a type of cognitive bias known as "circular reasoning"—reasoning that uses its conclusion as support for the argument itself.[144] According to the DOJ's report, the fingerprint examiner's interpretation of Mayfield's prints was influenced "by reasoning 'backward' from features that were visible in the known prints of Mayfield . . . [and] [h]aving found as many as 10 points of unusual similarity, the FBI examiners began to 'find' additional features in [the print found at the scene] that were not really there."[145] Many were surprised that this kind of bias was found in fingerprint analysis because experts and courts had long considered fingerprint analysis to be relatively objective[146] and even infallible.[147] This is, of course, not the case, and "the identification of similar visual patterns depends on human experience and judgment."[148] Like all human judgment, this analysis is vulnerable to bias.

Partly in response to the Mayfield case, in 2005, Congress authorized the National Academy of Sciences (NAS) to conduct a study on the state of forensic science in the United States.[149] In 2006, a committee appointed by the NAS was formed and, in 2009, released its report, *Strengthening Forensic Science in the United States: A Path Forward*.[150] As the report notes, psychiatrists and other mental health professionals often act as forensic scientists when they perform court-

143 *Id.*

144 *Id.* at 7; *see also* Lance J. Rips, *Circular Reasoning*, 26 COGNITIVE SCI. 767, 767 (2002) (explaining that when engaging in circular reasoning, "the arguer illicitly uses the conclusion itself (or a closely related proposition) as a crucial piece of support, instead of justifying the conclusion on the basis of agreed-upon facts and reasonable inferences").

145 FBI'S HANDLING OF THE MAYFIELD CASE, *supra* note 142, at 7.

146 *See, e.g.*, Itiel E. Dror et al., *Contextual Information Renders Experts Vulnerable to Making Erroneous Identifications*, 156 FORENSIC SCI. INT'L 74, 74 (2006). As Dror noted, "inconsistent identification decisions may reflect cognitive flaws and limitations in conducting objective and independent processing and evaluation of the information." *Id.* at 77.

147 *See* FED. BUREAU OF INVESTIGATION, U.S. DEP'T OF JUSTICE, THE SCIENCE OF FINGERPRINTS: CLASSIFICATION AND USES, at iv (1985) ("Of all the methods of identification, fingerprinting alone has proved to be both infallible and feasible. Its superiority over the older methods, such as branding, tattooing, distinctive clothing, photography, and body measurements (Bertillon system), has been demonstrated time after time. While many cases of mistaken identification have occurred through the use of these older systems, to date the fingerprints of no two individuals have been found to be identical.").

148 Scott, *supra* note 10, at 21.

149 COMM. ON IDENTIFYING THE NEEDS OF THE FORENSIC SCI. CMTY., NAT'L ACAD. OF SCI., STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES: A PATH FORWARD, at xix (2009), https://www.ncjrs.gov/pdffiles1/nij/grants/228091.pdf.

150 *Id.*

ordered evaluations.[151] The report recommends that "forensic disciplines that rely on subjective assessments of matching characteristics . . . need to develop rigorous protocols to guide these subjective interpretations and pursue equally rigorous research and evaluation programs."[152] Specifically, the report notes that these disciplines can benefit from "the findings of cognitive psychology on the potential for bias and error in human observers."[153]

The idea that bias affects the reliability of all scientific testimony may be a relatively recent finding, but there is no doubt that it has long been a concern for forensic psychiatric testimony. As one author put it, "[i]f reliability of fingerprint evidence is now called into question, what might this suggest for the scientific admissibility of forensic psychiatric evidence?"[154] Moreover, as AAPL notes in its ethical guidelines for forensic psychiatrists:

> The adversarial nature of most legal processes presents special hazards for the practice of forensic psychiatry. Being retained by one side in a civil or criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion. It is the responsibility of psychiatrists to minimize such hazards by acting in an honest manner and striving to reach an objective opinion.[155]

Although the NAS report did not specifically address forensic mental health evaluations, some commentators have suggested that forensic psychiatric education should better implement these recommendations by highlighting the role of bias and the conflicts of interest that arise from dual relationships.[156] While medical ethics education has become a priority at American medical schools in the past several decades,[157] the effects of bias, conflicts of interest, and "a doctor's inner feelings on his thinking get short shrift in medical training and in

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151 *Id.*

152 *Id.* at 8.

153 *Id.*

154 Scott, *supra* note 10, at 21.

155 AAPL FORENSIC PSYCHIATRY ETHICS GUIDELINES, *supra* note 24, § IV cmt.

156 *See* Scott, *supra* note 10, at 31 (discussing the findings of the NAS report and noting that "[f]orensic psychiatric education can help achieve that goal by providing increased training on standardized forensic assessment instruments and specific training regarding the impact of biases on assessment methodology and opinion formation"). *But see* Appelbaum, *Ethics and Forensic Psychiatry*, *supra* note 17, at 199 ("Training in the ethics of forensic psychiatry, which fellowship programs are required to provide, is part of the answer; but it may be too easy to push such training to the back of one's mind when one enters the world of practice.").

157 *See* Rachael E. Eckles et al., *Medical Ethics Education: Where Are We? Where Should We Be Going? A Review*, 80 ACAD. MED. 1143, 1143 (2005). All United States medical schools now require ethics courses in the undergraduate medical curriculum. *Id.*

research on decision-making."[158] One review of syllabi from fifty-eight United States medical schools, for example, found that in most medical schools, ethics education focused on informed consent, health care delivery, confidentiality and privacy, quality of life, death and dying, and physician-assisted suicide.[159] Conflicts of interest were included in ethical training in only 22.4% of syllabi.[160] Moreover, most of the published research on training in conflicts of interest seems to focus on conflicts that arise based on physician relationships with drug companies[161] and inappropriate sexual boundaries with patients.[162] Because psychiatrists and psychologists often do not receive training on conflicts that arise when professional roles are blurred, "the transition from the classroom or clinical setting to a forensic environment may involve a substantial paradigm shift and a corresponding struggle with the ethical, moral, and legal issues involved."[163]

Psychiatrists can receive additional training or certification in forensic psychiatry, including a forensic psychiatric fellowship, which focuses on law and forensic examinations.[164] Psychiatrists can also become board certified by the American Board of Psychiatry and

158 JEROME GROOPMAN, HOW DOCTORS THINK 36 (2007) (rejecting assumptions that "medical decision-making is an objective and rational process, free from the intrusion of emotion," and arguing instead that "[t]he physician's internal state, his state of tension, enters into and strongly influences his clinical judgments and actions").

159 *See* James M. DuBois & Jill Burkemper, *Ethics Education in U.S. Medical Schools: A Study of Syllabi*, 77 ACAD. MED. 432, 434 (2002). Most schools covered only six main content areas: "informed consent (85%), health care delivery (75%), confidentiality and privacy (67%), quality of life/futility/provision of treatment (67%), death and dying (66%), and euthanasia and physician-assisted suicide (60%)." *Id.*

160 *Id.* at 435 tbl.2.

161 *See, e.g.*, Troyen A. Brennan et al., *Health Industry Practices that Create Conflicts of Interest: A Policy Proposal for Academic Medical Centers*, 295 J. AM. MED. ASS'N 429, 429 (2006) ("The current influence of market incentives in the United States is posing extraordinary challenges to the principles of medical professionalism. . . . Arguably, the most challenging and extensive of these conflicts emanate from relationships between physicians and pharmaceutical companies and medical device manufacturers.").

162 *See, e.g.*, Gillian E. White, *Medical Students' Learning Needs About Setting and Maintaining Social and Sexual Boundaries: A Report*, 37 MED. EDUC. 1017, 1017 (2003) ("Despite increasing awareness of the potentially harmful consequences of social and sexual relationships between doctors and patients, little assessment has been made of the learning needs of medical students for setting and maintaining social and sexual boundaries in the doctor–patient relationship.").

163 BUSH ET AL., *supra* note 45, at 16.

164 *See, e.g.*, *Forensic Fellowship Program Description*, ALBERT EINSTEIN C. MED., http://www.einstein.yu.edu/psychiatry/residency/forensic.htm (last visited June 18, 2015) ("Fellows will leave with an in-depth knowledge of: psychiatric evaluation of individuals involved with the legal system[;] the specialized psychiatric treatment required by those who have been incarcerated in jails, prisons, or special forensic psychiatric hospital[;] [and] legal regulation of general psychiatric practice.").

Neurology in the subspecialty of forensic psychiatry.[165] Psychologists can be similarly certified by the American Board of Forensic Psychologists.[166] While clinicians with advanced training and certification may have spent more time focusing on the ethical concerns raised by dual relationships, courts do not require expert witnesses to have such training or certification.[167] Moreover, individuals other than forensic psychiatrists and psychologists—including psychologists and other mental health professionals whose primary job is that of a therapist—often give forensic testimony.[168] Many of these individuals do not receive any additional training in forensic ethics, perhaps because they do not view themselves as forensic psychologists, but rather as therapists who are also providing testimony in a legal proceeding.[169]

The professional literature suggests that most clinicians are aware that dual relationships create a potential conflict of interest leading to bias, but many appear to believe that they can resist the influence of a clinical relationship on any subsequent forensic testimony.[170] This expectation that clinicians can somehow overcome bias differs from other areas of medicine generally, and from psychiatry specifically, where explicit attempts are made to address and remove bias and conflicts of interest. When clinicians conduct clinical research, for instance, the results of that research are "double-masked" or "double-blind" and neither the researcher nor the patient know which treatment the patient is receiving.[171] This standard ensures that the study minimizes the bias that can occur in both assignment to a treatment

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165 *See General Requirements*, AM. BOARD PSYCHIATRY & NEUROLOGY, http://www.abpn.com/become-certified/general-requirements (last visited June 18, 2015); *see also Forensic Psychiatry*, AM. BOARD PSYCHIATRY & NEUROLOGY, http://www.abpn.com/become-certified/taking-a-subspecialty-exam/forensic-psychiatry (last visited Feb. 3, 2016).

166 *See Forensic Psychology*, AM. BOARD PROF'L PSYCHOL., http://www.abpp.org/i4a/pages/index.cfm?pageid=3356 (last visited June 18, 2015).

167 *See* FED. R. EVID. 702.

168 *See* Greenberg & Shuman, *supra* note 120, at 50 (noting that psychologists, psychiatrists, and other mental health professionals are acting as expert witnesses on behalf of their patients with increasing frequency).

169 *Id.* at 51 ("When these clinicians eventually testify in court, they see themselves as benignly telling the court about their patients and perhaps even benevolently testifying on behalf of their patients. Therapists are not typically trained to know that the rules of procedure, rules of evidence, and the standard of proof is different for court room testimony than for clinical practice.").

170 *See* Daylian M. Cain & Allan S. Detsky, Commentary, *Everyone's a Little Bit Biased (Even Physicians)*, 299 J. AM. MED. ASS'N 2893, 2893 (2008).

171 *Institutional Review Board Guidebook: Chapter IV Considerations of Research Design*, OFF. FOR HUM. RES. PROTECTIONS, http://www.hhs.gov/ohrp/archive/irb/irb_chapter4.htm (last updated 1993) [hereinafter IRB GUIDEBOOK] (defining a double-masked study design as one "in which neither the investigators nor the subjects know the treatment group assignments of individual subjects"); *see also* Cain & Detsky, *supra* note 170, at 2895.

group and assessment of the study's outcome.[172] As one author notes of this apparent discrepancy in the forensic setting, "[r]esearchers are not insulted by the imposition of these methods in research. Why then are they so insulted by the suggestion that similar influences might have affected their beliefs in other settings?"[173]

It may be that some psychiatrists and psychologists believe that their medical training and professionalism allow them to evaluate evidence objectively and consciously remove bias from their decision making. Yet the social science literature on bias tells us that this assumption "may be based on an incorrect understanding of human psychology."[174] Conflicts of interest may result from bias that is unintentional, and therefore cannot be easily eliminated from decision making, even by an ethical and conscientious psychiatrist who is attempting to give truthful testimony in a legal proceeding.[175]

Like all people, mental health professionals are prone to cognitive errors or bias.[176] Biases are the preferences that influence impartial judgment, and one author has argued that the majority of mistakes in modern medicine are due to errors in thinking instead of errors in technique and that "most misguided care results from a cascade of cognitive errors."[177] Psychiatrists and psychologists, of course, are not immune from these errors, and bias can have a profound effect on

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172 IRB GUIDEBOOK, *supra* note 171. As the guidelines note:

> Good methodology requires that studies be designed to minimize bias both in assignment to treatment groups (*e.g.*, by randomizing) and in assessment of outcome. Bias may enter into a study in several ways. The investigator may have strong beliefs or hopes regarding the success of a particular intervention or the truth of a particular hypothesis; these expectations may unconsciously influence his or her evaluation of the outcome of the research. To avoid this possibility, it is now accepted and preferred practice to conduct controlled investigations by dividing subjects into at least two groups: those who receive the experimental intervention (the experimental or treatment group) and those who do not (the control group).

Id.; *see also* Ezekiel J. Emanuel et al., *What Makes Clinical Research Ethical?*, 283 J. AM. MED. ASS'N 2701, 2704 (2000) ("[R]esearch that uses biased samples, questions, or statistical evaluations . . . is thus unethical.").

173 Cain & Detsky, *supra* note 170, at 2895.

174 *Id.* at 2893.

175 *Id.* As the authors note, conflicts of interest are problematic because they are widespread and "also because most people incorrectly think that succumbing to them is due to intentional corruption, a problem for only a few bad apples. . . . [On the contrary,] succumbing to a conflict of interest is more likely to result from unintentional bias, something common in everyone." *Id.*

176 *See* GROOPMAN, *supra* note 158, at 260 ("Different doctors have different styles of practice, different approaches to problems. But all of us are susceptible to the same mistakes in thinking."); *see also* Michael Makhinson, *Biases in the Evaluation of Psychiatric Clinical Evidence*, 200 J. NERVOUS & MENTAL DISEASE 76, 79 (2012) ("Simply put, it is difficult for everyone, including clinicians, to change beliefs and behaviors.").

177 GROOPMAN, *supra* note 158, at 260; *see also* TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (Linda T. Kohn et al. eds., 2000) (reporting that "at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors").

forensic mental health testimony.[178] In the case of a clinician who offers forensic testimony about a patient with whom she also has a clinical relationship, many of these biases might have even more influence. Because a clinician "must enter into the patient's subjectivity to see the world through the patient's eyes," this empathetic engagement with the patient creates bias that can prevent objective forensic testimony.[179]

Because of the ambiguities inherent in mental health diagnosis and forensic assessment, "[c]onfirmation bias may be the most common cognitive error in psychiatry."[180] When people are confronted with new information, they tend to devote less attention to examining information that contradicts those beliefs,[181] or ignore ways in which the new information is inconsistent with their preexisting beliefs.[182] This tendency is known as "confirmation bias," and it affects the ways in which people notice and evaluate information.[183] Unlike many medical symptoms, mental health symptoms can be interpreted in a variety of ways and this ambiguity can lead to confirmation bias in diagnosis.[184] For example:

> [T]he decision whether or not to diagnose psychosis and start the patient on a year or a lifetime of antipsychotic medications may hang on the interviewer's idiosyncratic interpretation of the patient's experiences, or the subjective distinctions between a delusion and an overvalued idea, or between a "true" and "pseudo-" hallucination.[185]

Moreover, psychiatrists may be prone to confirmation bias in the prescription of medication. For example, a psychiatrist may pay more attention to clinical trials that support their current medication practices and minimize the importance of other trials that challenge those practices.[186]

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178 *See* Scott, *supra* note 10, at 27. Scott lists eight potential types of bias that might influence psychiatric forensic testimony, including anchoring bias, attribution bias, confirmation bias, conformity bias, halo effect, hindsight bias, observer bias, and overconfidence bias. *Id.*

179 APPELBAUM & GUTHEIL, *supra* note 20, at 235.

180 Niall Crumlish & Brendan D. Kelly, *How Psychiatrists Think*, 15 ADVANCES PSYCHIATRIC TREATMENT 72, 76 (2009).

181 *See* Peter H. Ditto & David F. Lopez, *Motivated Skepticism: Use of Differential Decision Criteria for Preferred and Nonpreferred Conclusions*, 63 J. PERSONALITY & SOC. PSYCHOL. 568, 569 (1992).

182 *See* Dieter Frey, *Recent Research on Selective Exposure to Information*, *in* 19 ADVANCES IN EXPERIMENTAL SOCIAL PSYCHOLOGY 41, 42 (Leonard Berkowitz ed., 1986).

183 JENNIFER K. ROBBENNOLT & JEAN R. STERNLIGHT, PSYCHOLOGY FOR LAWYERS: UNDERSTANDING THE HUMAN FACTORS IN NEGOTIATION, LITIGATION, AND DECISION MAKING 15 (2012).

184 Crumlish & Kelly, *supra* note 180, at 76.

185 *Id.*

186 *See* Makhinson, *supra* note 176, at 79 ("[P]sychiatrists who still believe that second-generation antipsychotics have superior efficacy over first-generation antipsychotics in the treatment of schizophrenia may cite numerous early studies that support this but discount more recent larger higher-quality studies.").

Forensic evaluators who have a preexisting clinical relationship with a patient may also be prone to "treater bias," where the clinician is "subject to a bias in favor of the examinee based on unconsciously experiencing the relationship as doctor-patient."[187] It can be difficult, if not impossible, to transition from the role of a treating clinician to the role of a forensic expert for the same patient. The clinician's medical training and dedication to the patient's best interest may influence the objectivity and candor required of an expert witness. Specifically, the "empathic subjectivity of the treater role" might be a major biasing factor, which could cause her to "stretch relevant forensic criteria 'to aid a patient.'"[188] Treater bias can therefore be viewed as an extension of confirmation bias. Because the treating psychiatrist has been trained and is motivated to act in her patient's best interest, she may unconsciously tend to pay attention to information that will support a legal outcome that is in her patient's best interest, and to view more critically information that is not.[189]

Another related type of bias that may influence the treating psychiatrist's decision making is the affect error or affect heuristic.[190] This type of bias can occur when a clinician's decision making is biased by her desire for a certain outcome to occur, such as seeing a patient do well.[191] Similarly, a treating clinician's hope for a good outcome for her patient may cause her to interpret facts in a way that promotes that

187 Thomas G. Gutheil & Robert I. Simon, *Avoiding Bias in Expert Testimony*, 34 PSYCHIATRIC ANNALS 260, 261 (2004).

188 *Id.* The authors note that these conclusions are based on their respective consultative experiences, and there do not appear to be any published studies on the effects of the "treater bias." *Id.* Nevertheless, one can imagine that this would be a likely result of the conflict that results from such dual-role relationships. Moreover, extensive studies on confirmation bias do suggest that psychiatrists and other physicians are prone to this kind of selective information processing. *See generally supra* notes 138–87 and accompanying text.

189 This type of critical evaluation of information is known as "biased assimilation." Charles G. Lord et al., *Biased Assimilation and Attitude Polarization: The Effects of Prior Theories on Subsequently Considered Evidence*, 37 J. PERSONALITY & SOC. PSYCHOL. 2098, 2099 (1979) (describing biased assimilation as the tendency of individuals to "dismiss and discount empirical evidence that contradicts their initial views, but . . . derive support from evidence, of no greater probativeness, that seems consistent with their views"). When people evaluate new information, therefore, that evaluation can be influenced by the extent to which it is consistent or inconsistent with the person's expectations about the new information. *See* APPELBAUM & GUTHEIL, *supra* note 20, at 235. "When we come across evidence that supports our desired conclusions, we may accept it at face value. But when we come across comparable evidence that challenges our desired conclusions, we may evaluate it more critically and work hard to refute it." ZIVA KUNDA, SOCIAL COGNITION: MAKING SENSE OF PEOPLE 230 (1999).

190 *See* Crumlish & Kelly, *supra* note 180, at 76–77.

191 *See id.* at 74 ("A doctor may allow positive feelings towards a patient to influence their clinical judgement [sic]: because the doctor wishes the patient well, a symptom may be interpreted benignly when a more ominous interpretation is valid."); *see also generally* Melissa L. Finucane et al., *The Affect Heuristic in Judgments of Risks and Benefits*, 13 J. BEHAV. DECISION MAKING 1 (2000).

outcome. This bias is similar to confirmation bias: if either of two plausible outcomes is possible, the clinician may interpret the information in a way that promotes the best outcome for her patient.[192] While this bias can of course be unconscious, it also seems possible to imagine a scenario in which a treating psychiatrist might consciously choose between two justifiable conclusions when one produces a better outcome for an existing patient.[193]

Although typically discussed in the therapeutic setting, transference is another type of unconscious bias that all people—not just individuals receiving mental health treatment—experience.[194] For example, people often react to other people quickly, both consciously and unconsciously, based on what the other person represents.[195] In this way, stereotyping is a type of transference, in which "behavioral information about one group member is applied to the group as a whole and is transferred to other group members."[196] In the therapeutic setting, transference is the patient's direction of previous feelings towards a new object: the therapist.[197] Countertransference, in contrast, is specific to the therapeutic context and can be described as the emotional response a clinician has toward her patient and the patient's previous behavior.[198] Countertransference includes "all feelings, whether

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192 *See* Crumlish & Kelly, *supra* note 180, at 76; *see also* Greenberg & Shuman, *supra* note 120, at 56 ("Therapists are usually highly invested in the welfare of their patients and rightfully concerned that publicly offering some candid opinions about their patient's deficits could seriously impair their patient's trust in them. . . . They are usually sympathetic to their patient's plight, and they usually want their patient to prevail.").

193 *See* Crumlish & Kelly, *supra* note 180, at 77 ("[A] psychiatrist may be aware of all possible diagnoses in a particular case, may be aware of the influence of hope on decision-making, and may still be faced with enduring diagnostic uncertainty."); *see also* Greenberg & Shuman, *supra* note 120, at 56 ("Engaging in conflicting therapeutic and forensic relationships exacerbates the danger that experts will be more concerned with case outcome than the accuracy of their testimony.").

194 *See* S. Pirzada Sattar et al., *Countering Countertransference: A Forensic Trainee's Dilemma*, 30 J. AM. ACAD. PSYCHIATRY & L. 65, 67 (2002) [hereinafter Sattar et al., *Forensic Trainee's Dilemma*].

195 *See* Lisa A. Mellman, *Countertransference in Court Interpreters*, 23 BULL. AM. ACAD. PSYCHIATRY & L. 467, 467 (1995) ("Transference is an unconscious process in which people inappropriately place emotional reactions or patterns of behavior that originated with significant people of their past onto others in their current life. . . . 'Transference accounts for the instant like or dislike of a person upon first encounter.'" (quoting EDWIN R. WALLACE, IV, DYNAMIC PSYCHIATRY IN THEORY AND PRACTICE 27 (1983))).

196 Matthew T. Crawford et al., *Perceived Entitativity, Stereotype Formation, and the Interchangeability of Group Members*, 83 J. PERSONALITY & SOC. PSYCHOL. 1076, 1076 (2002).

197 *See* ROBERT J. KOHLENBERG & MAVIS TSAI, FUNCTIONAL ANALYTIC PSYCHOTHERAPY: CREATING INTENSE AND CURATIVE THERAPEUTIC RELATIONSHIPS 170–71 (1991).

198 *See* S. Pirzada Sattar et al., *Countering Countertransference, II: Beyond Evaluation to Cross-Examination*, 32 J. AM. ACAD. PSYCHIATRY & L. 148, 148 (2004) [hereinafter Sattar et al., *Beyond Evaluation*]. The concept of countertransference was first introduced by Sigmund Freud to describe "the therapist's unconscious response to the patient, based on the therapist's unresolved conflicts." Sattar et al., *Forensic Trainee's Dilemma*, *supra* note 194, at 65. This

conscious, subconscious, or unconscious, that are evoked in forensic examiners during evaluation or testimony, in response to examinee and nonexaminee variables that have the potential to have an impact on the objectivity of their forensic opinions."[199] This emotional response "can create an impediment to giving an honest and unbiased opinion."[200]

Countertransference can be positive or negative.[201] For instance, in the civil context, a forensic examiner might have developed a close therapeutic alliance with an existing patient and give biased testimony that is more likely to lead to a positive legal outcome for the patient. In the criminal context, if a defendant is accused of a serious or heinous crime, this could evoke a strong negative emotional response in the mental health professional performing the forensic examination and bias any resulting testimony against the defendant.[202] Whether the countertransference is negative or positive, however, it "can affect the objectivity of the final forensic evaluation."[203] Because of the significant role the forensic mental health professional can play in legal proceedings, it is essential that she be aware of the impact this type of bias can have on a forensic evaluation.[204] When forensic and clinical roles are mixed, however, it can be even more difficult for the forensic mental health professional to identify and manage countertransference methods.

Finally, many commentators express concern about "allegiance bias,"[205] or the "the hired gun phenomenon," which is the "perception that expert testimony frequently reflects who is paying the clinician and not an impartial assessment of the merits of a case."[206] Indeed, it is not

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definition was then broadened to include "all natural reactions that the therapist has to the patient's outrageous behavior." *Id.* Although the concept of countertransference was originally introduced in the clinical setting, forensic mental health professionals are also vulnerable to this type of unconscious bias towards an evaluee, and the literature on forensic mental health "suggests adding a modifier to the word countertransference, such as 'forensic countertransference' in an attempt to add a degree of clarity to this concept." Sattar et al., *Beyond Evaluation*, *supra*, at 152.

199 Sattar et al., *Beyond Evaluation*, *supra* note 198, at 152.

200 Sattar et al., *Forensic Trainee's Dilemma*, *supra* note 194, at 65.

201 *See id.* at 68.

202 *See* Sattar et al., *Beyond Evaluation*, *supra* note 198, at 149; *see also* Adam J. Goldyne, *Minimizing the Influence of Unconscious Bias in Evaluations: A Practical Guide*, 35 J. AM. ACAD. PSYCHIATRY & L. 60, 60 (2007) ("Emotions such as anger, pity, guilt, affection, resentment, disdain, humiliation, and others may give rise to unconscious motivations that conflict with the motivation to be objective.").

203 Sattar et al., *Forensic Trainee's Dilemma*, *supra* note 194, at 68.

204 *Id.*

205 Thomas Munder et al., *Researcher Allegiance in Psychotherapy Outcome Research: An Overview of Reviews*, 33 CLINICAL PSYCHOL. REV. 501, 501 (2013) (describing researcher allegiance as "a risk of bias in psychotherapy outcome research").

206 Douglas Mossman, *"Hired Guns," "Whores," and "Prostitutes": Case Law References to Clinicians of Ill Repute*, 27 J. AM. ACAD. PSYCHIATRY & L. 414, 414–15 (1999). Mossman

just a perception. One study found a tendency of "some experts who score ostensibly objective assessment instruments [to] assign scores that are biased toward the side that retained them."[207] Participants were 108 forensic psychologists who were paid to review sex offender files and score them on two commonly used risk assessment measures.[208] Although the participants spent only fifteen minutes with the retaining attorney, "the risk scores assigned by prosecution and defense experts showed a clear pattern of adversarial allegiance."[209] As the authors noted, these results were especially significant because the short time the experts spent with the retaining attorney was significantly less than they would have if they had been retained in an actual case and the "experimental manipulation was less powerful than the forces experts are likely to encounter in most real cases."[210]

Allegiance bias can, of course, cut both ways. Allegiance bias towards a patient can occur in conjunction with the affective heuristic or treater bias.[211] One can imagine that this allegiance bias would only be heightened in cases where the forensic expert has a preexisting therapeutic relationship with the client. And allegiance bias towards the state or prosecuting attorney can also occur, especially in jurisdictions where a mental health professional is regularly retained by the state as a professional expert.[212] To the extent that this type of unconscious bias does exist, one author suggests that it can be reduced by, among other

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conducted a search of published court decisions that "make, or refer to, derogatory statements concerning mental health experts." *Id.* at 414. He found 567 cases, "45 (7.9%) of which contained comments about professionals' ethics. In 35 opinions, professionals were termed or compared with 'hired guns'; five cases described testifying experts using the word 'whore,' and five cases used some variation on 'prostitute.'" *Id.*

207 Daniel C. Murrie et al., *Are Forensic Experts Biased by the Side that Retained Them?*, 24 PSYCHOL. SCI. 1889, 1895 (2013); *see also* Neil Vidmar & Nancy MacDonald Laird, *Adversary Social Roles: Their Effects on Witnesses' Communication of Evidence and the Assessments of Adjudicators*, 44 J. PERSONALITY & SOC. PSYCHOL. 888, 895 (1983) (concluding that the "placing of witnesses i[n] an adversary role induces bias in subsequent testimony," that "[t]he bias effect is subtle, and the evidence suggests that the witnesses were probably unaware of it").

208 The first was the Psychopathy Checklist–Revised (PCL-R), which is a "20-item measure of interpersonal, emotional, and behavioral traits, which clinicians score on the basis of an offender's records and a clinical interview." Murrie et al., *supra* note 207, at 1892. The second was the Static 99-R, which is "[c]omposed of 10 items that address an offender's age and prior living arrangements, as well as several aspects of his offense history." *Id.*

209 *Id.* at 1893 ("As expected, allegiance effects were stronger for the PCL-R, a measure that requires more subjective clinical judgment, than for the Static-99R, a measure that requires less clinical judgment.").

210 *Id.* at 1895; *see also* Daniel C. Murrie et al., *Does Interrater (Dis)agreement on Psychopathy Checklist Scores in Sexually Violent Predator Trials Suggest Partisan Allegiance in Forensic Evaluations?*, 32 L. & HUM. BEHAV. 352, 352 (2008) (finding that clinician's psychopathy checklist scores for sexually violent predators "were usually in a direction that supported the party who retained their services").

211 *See supra* text accompanying notes 187–93.

212 *See, e.g.*, *supra* text accompanying notes 36–37.

things, enforcement of ethical standards and better training for forensic clinicians.[213]

Given the impact that unconscious bias can have on decision making, many mental health professionals believe that true objectivity among forensic mental health experts is an unrealistic expectation. As one author put it when describing his work on the creation of AAPL's Ethical Guidelines relating to dual relationships, "[a]fter much debate, a Quaker-like consensus emerged that the achievement of objectivity by forensic psychiatrists . . . is an illusive goal. It is better to be straightforward with ourselves and others; the best we could hope for is to approach objectivity asymptotically."[214] Of course, this lack of true objectivity can be found in all professions and all people—everyone is vulnerable to bias. In striving for objectivity, however, forensic psychiatrists must be aware of bias and its effects, and "constantly vigilant to the influence of bias."[215] In attempting to counteract existing bias, many professionals in the forensic mental health field have called for greater education and study of forensic mental health testimony and bias.[216]

But in addition to greater education within the mental health fields about the bias that exists when dual relationships are created, courts should also be more aware of how these conflicting roles can affect the reliability of forensic testimony. And while "[i]t is the responsibility of the psychologist to provide education to those who do not appreciate the threats to impartiality and to attempt to maintain clear distinctions in professional roles,"[217] it is also up to the legal system to appropriately consider the admissibility of forensic expert testimony when a dual forensic and clinical relationship forms the basis of that testimony.

C. *Disclosure Does Not Mitigate the Harm*

While the ethical guidelines for both forensic psychiatrists and psychologists strongly discourage dual relationships, neither explicitly prohibits the practice.[218] Instead, when a single clinician enters into both a clinical and forensic role with a single patient, she should "explicitly

213 *See* Mossman, *supra* note 206, at 415.

214 Ciccone, *supra* note 23, at 34.

215 *Id.* at 36 ("Bias, like Zeus transforming into a bull or swan, can take many forms.").

216 *See id.* (noting that "[a] model curriculum for teaching about bias in forensic psychiatric work would make a great start to being more attentive to the effects of bias" and recommending that the AAPL Education Committee take on this important task).

217 BUSH ET AL., *supra* note 45, at 15.

218 *See supra* discussion Section I.A.

inform the evaluee that the psychiatrist is not the evaluee's 'doctor'"[219] or "disclose the potential risk" to the patient.[220] But even if a patient is informed at the outset that the same clinician will perform both a forensic and clinical role, "it is difficult to imagine how open communication and effective treatment can take place" under these circumstances.[221]

Disclosure can be ineffective in the case of a dual relationship, however, because of the dramatically different, and sometimes conflicting, roles played by mental health professionals in forensic and clinical settings. A forensic evaluator is distinguished from a treating clinician due to the difference in agency.[222] The treating clinician is the agent of the patient, while the forensic evaluator is an agent of the court.[223] Even if a patient is told at the outset that the clinician is performing a dual role and that the outcome of the forensic evaluation may not have a positive outcome, "subjects often slip back into a therapeutic mindset."[224] This occurs for several reasons. First, a patient who is involved in a legal proceeding is understandably under a great deal of stress, which may encourage the person to confide in the clinician.[225] This "regression" back to the therapeutic relationship "may pose a problem in which the subject's openness may yield evidence damaging . . . in court."[226] Similarly, a patient with an existing relationship with a clinician may consciously or unconsciously transfer feelings associated with the previous clinical relationship—including trust and transparency—to the new evaluative relationship.[227] Finally, the patient may simply have "wishful confusion," which makes them unable to grasp the new agency.[228] This resistance, "out of a wish for help combined with confusion about the situation," can be compounded by the stress of litigation.[229]

Moreover, patients and clinicians have different expectations of the nature and purpose of forensic evaluations and clinical treatment, and when those roles are blurred, it may be difficult to adequately communicate the change to the patient. For example, the informed

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219 AAPL FORENSIC PSYCHIATRY ETHICS GUIDELINES, *supra* note 24, § II cmt.

220 APA SPECIALTY GUIDELINES, *supra* note 25, at 11, § 4.02.01.

221 Appelbaum, *Ethics in Evolution*, *supra* note 78, at 446.

222 *See* APPELBAUM & GUTHEIL, *supra* note 20, at 235.

223 *See id.*; *see also* BUSH ET AL., *supra* note 45, at 12 (noting that while psychologists providing treatment form a therapeutic alliance with patients, "[t]he psychologist retained as an expert witness forms an alliance with the truth").

224 APPELBAUM & GUTHEIL, *supra* note 20, at 236.

225 *Id.*

226 *Id.*

227 *Id.*

228 *Id.*

229 *Id.*

consent doctrine applies to the therapeutic setting as patients have "a choice about whether to accept or refuse the intervention; the decision must be made in a knowing, intelligent, and voluntary way."[230] When a forensic evaluation is court ordered, however, the individual does not typically have a choice to participate. Instead, the clinician should communicate the purpose of the examination and explain that information the individual reveals could be used against her in a legal proceeding.[231] For this reason, "the 'intelligent' aspect of decision-making is less important, and the 'voluntary' component clearly does not apply."[232]

When the purposes of the therapeutic and forensic roles are combined or changed, it can be difficult for patients to understand this change, and patients "may be insufficiently attentive to the risks involved in forensic proceedings."[233] This is especially true in cases where the clinician initially acted in a therapeutic role because the patient may trust that her therapist will continue to act in her best interest and therefore, the patient may disregard or minimize any notification that the traditional protections of the already developed therapeutic relationship no longer apply. Moreover, when a criminal defendant is admitted to an inpatient setting for both evaluation and treatment, she must simultaneously consent to treatment and receive notice of the purposes of evaluation.[234] Often, defendants are told to complete a form acknowledging that they understand that information they reveal during treatment may be later used against them in court.[235] In the case of a seriously mentally ill defendant, however, it is difficult to imagine that the individual could understand the different purposes of the forensic evaluation and the corresponding clinical treatment and be able to give meaningful informed consent.

Furthermore, disclosure of the conflict to the patient is appropriate, but is not enough to eliminate the conflict. To be effective, disclosure must give the patient an understanding of how the conflict of interest will influence the mental health professional and allow the patient to "correct for that biasing influence."[236] Yet several studies on the disclosure of conflicts of interest "suggest[] that [patients] are not very

230 HEILBRUN, *supra* note 21, at 70 n.4.

231 *Id.*

232 *Id.*

233 *Id.* at 71.

234 *Id.* at 143.

235 *See, e.g.*, *Consent for Forensic Psychiatric Evaluation*, U. PITTSBURGH MED. CTR., http://www.upmc.com/locations/hospitals/western-psychiatric/services/professional/forensic-psychiatry/Documents/sample-consent.pdf (last visited Feb. 4, 2016).

236 Daylian M. Cain et al., *The Dirt on Coming Clean: Perverse Effects of Disclosing Conflicts of Interest*, 34 J. LEGAL STUD. 1, 3 (2005).

concerned about the information they receive."[237] One meta-study found that although most patients expressed a desire to know about a physician's financial ties to drug companies, most were not concerned about the conflict and did not believe it would affect their decision making.[238]

Other studies have found that disclosure could actually have a negative impact on the doctor-patient relationship and may impair the therapeutic relationship. For example, one study asked subjects to play the role of hypothetical patients who were given a medical history and current symptoms.[239] Each subject then heard a recording of their "doctor," who told them about treatment options and made a recommendation.[240] The recommended treatment option benefited the doctor financially, but this financial benefit was only disclosed to one group of subjects, while the other group was given no additional information.[241] Although both groups of subjects received identical medical advice, the patients who were given the disclosure "reported trusting the doctor significantly less . . . , were less likely to believe that their doctor had their best interests at heart, and were less likely to indicate that they would consult with that particular doctor again in the future."[242] In other words, "[d]isclosure had damaged the doctor-patient relationship."[243]

Finally, unlike other types of conflicts of interest, the role conflict that dual relationships create is not one that the patient should be permitted to waive because it is a conflict that affects people other than the patient.[244] The court, the parties, and the patient are all affected by the conflict and the resulting biased testimony that may result from dual relationships.

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237 George Loewenstein et al., *The Limits of Transparency: Pitfalls and Potential of Disclosing Conflicts of Interest*, 101 AM. ECON. REV.: PAPERS & PROC. 423, 424 (2011) (discussing various studies).

238 *See* Adam Licurse et al., *The Impact of Disclosing Financial Ties in Research and Clinical Care: A Systematic Review*, 170 ARCHIVES INTERNAL MED. 675, 680 (2010); *see also* Lindsay A. Hampson et al., *Patients' Views on Financial Conflicts of Interest in Cancer Research Trials*, 355 NEW ENG. J. MED. 2330, 2330 (2006) (finding that that over ninety percent of patients in cancer research trials "expressed little or no worry" that researchers in the study had financial ties to drug companies).

239 *See* Loewenstein et al., *supra* note 237, at 426.

240 *Id.*

241 *Id.*

242 *Id.*

243 *Id.*

244 *See* Greenberg & Shuman, *supra* note 120, at 54.

III. RECOMMENDATIONS

A. *Courts Should Not Admit Forensic Testimony Based on Dual-Role Relationships*

Federal Rule of Evidence (FRE) 702 and *Daubert* govern the admissibility of expert forensic testimony.[245] And while the methodology and ethical use of forensic mental health testimony based on dual relationships does not fit precisely into the *Daubert* framework, it is still an appropriate framework under which to analyze the admissibility of that evidence. *Daubert* clarified that FRE 702 requires judges to make two distinct inquiries when determining the admissibility of forensic testimony.[246] One of these inquiries, whether the testimony will "assist the trier of fact to understand the evidence or to determine a fact in issue," goes "primarily to relevance,"[247] and is a question of "fit."[248] If the proposed testimony is "sufficiently tied to the facts of the case that it will aid the jury in resolving a factual dispute," it survives this inquiry.[249] Forensic mental health testimony, whether or not it is the product of a dual relationship, does seem to satisfy this test. Such testimony would presumably be relevant to the legal proceeding and tailored to assist the trier of fact in reaching a decision about the individual's mental state.

FRE 702's other inquiry, however, focuses on the underlying methodology of the "scientific, technical, or other specialized knowledge."[250] As the *Daubert* court noted, "'[S]cientific' implies a grounding in the methods and procedures of science. Similarly, the word 'knowledge' connotes more than subjective belief or unsupported speculation. The term 'applies to any body of known facts or to any body of ideas inferred from such facts or accepted as truths on good grounds.'"[251] In other words, this requirement goes to reliability. In determining the reliability of the scientific knowledge that forms the basis of expert testimony, *Daubert* instructs judges to consider whether the theory or technique has been tested, whether it has been subjected to peer review and publication, whether there is a known or potential rate of error, whether there are standards controlling the technique's

245 *See supra* discussion Section I.B.

246 Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579 (1993).

247 *Id.* at 591 (first quoting FED. R. EVID. 702).

248 *Id.* (quoting United States v. Downing, 753 F.2d 1224, 1242 (3d Cir. 1985)).

249 *Id.* (quoting *Downing*, 753 F.2d at 1242).

250 FED. R. EVID. 702(a).

251 *Daubert*, 509 U.S. at 589–90 (quoting *Knowledge*, WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (1986)).

operation, and finally, whether the technique has been generally accepted by the relevant scientific community.[252] In other words, requiring that "an expert's testimony pertain to 'scientific knowledge' establishes a standard of evidentiary reliability."[253]

Although there are standards controlling various *types* of forensic evaluations,[254] and different kinds of forensic mental health evidence have been tested,[255] forensic mental health testimony based on a dual relationship cannot be easily evaluated under these factors. Moreover, this type of testimony is not a scientific technique for which there is a known potential rate of error. However, as noted above, many authors have written in peer-reviewed journals about the impropriety of the practice, and there is a general consensus in the mental health community that clinicians should not engage in dual-role relationships with patients.[256] Moreover, the inquiry under *Daubert* is meant to be a flexible one, with the focus "solely on principles and methodology, not on the conclusions that they generate."[257] Furthermore, *Daubert* explicitly retained *Frye*'s general acceptance test, and noted that widespread acceptance in the relevant professional field is an important factor to consider when weighing the admissibility of expert testimony, and that methods that are not widely accepted should be viewed cautiously.[258]

If we, therefore, consider forensic mental health testimony under the most applicable *Daubert* factors—general acceptance and peer review—such testimony should be excluded as unreliable under *Daubert*. The psychological and psychiatric literature expresses overwhelming support for minimizing the practice of dual relationships and for exercising caution when relying on information gained as a result of forensic evaluations when a clinician also has a therapeutic relationship with the patient.[259] Moreover, the ethical codes for both professions explicitly warn clinicians against the practice.[260] And while neither code affirmatively prohibits the practice, "[t]he articulation of the minimum requirements for valid opinions or assessments in the ethical code or

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252 *Id.* at 592–94.

253 *Id.* at 590.

254 *See, e.g.*, Mossman et al., *supra* note 39, at S3.

255 *See, e.g.*, Michael A. Norko & Madelon V. Baranoski, *The Prediction of Violence; Detection of Dangerousness*, 8 BRIEF TREATMENT & CRISIS INTERVENTION 73, 73 (2008).

256 *See supra* discussion Section I.A.

257 *Daubert*, 509 U.S. at 595.

258 *Id.* at 594 ("Widespread acceptance can be an important factor in ruling particular evidence admissible, and 'a known technique which has been able to attract only minimal support within the community' may properly be viewed with skepticism." (citation omitted) (quoting United States v. Downing, 753 F.2d 1224, 1238 (3d Cir. 1985))).

259 *See supra* Section I.A.

260 *See supra* Section I.A.

guidelines of the profession in which the expert bases a claim of expertise, goes to the heart of the admissibility requirements articulated in both *Frye* and *Daubert*."[261]

Dual relationships are considered by most professionals in the mental health community to be unethical, and forensic assessments based on dual relationships are considered to be unreliable.[262] Psychologists and psychiatrists should apply the same rigorous standards of professionalism and ethics that they give to their clinical practice to their legal testimony.[263] And while courts are not obligated to ensure the professionalism of mental health professionals outside of the courtroom, they should look to professional norms to ensure that forensic testimony is reliable. As one author noted, "[t]o the extent that ethics governs all scientific and professional behavior—which it does—it is only appropriate that it become the first metric against which to judge the expert witnessing of scientists and professionals."[264]

Although the conflict of interest created by dual relationships arises frequently in the courtroom, no published legal opinions address the practice. Because courts may not be aware of the ethical concerns or risks of unreliable or inaccurate testimony when a mental health professional is serving dual roles, some authors have recommended that courts look to relevant professional ethical norms when evaluating the admissibility of forensic mental health testimony.[265] By looking to professional ethics and norms, judges can "distinguish those experts who legitimately offer scientific testimony from those who misuse the opportunity for other motives and, in so doing, mislead the court."[266] Courts, however, seem unwilling to evaluate forensic mental health testimony based on the witnesses' ethical code of conduct.

In one of the few published decisions discussing psychological ethical guidelines as they apply to witness testimony, the court rejected an argument that professional ethical guidelines should dictate the admissibility of expert testimony.[267] In *Baskerville v. Culligan*

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261 Daniel W. Shuman & Stuart A. Greenberg, *The Role of Ethical Norms in the Admissibility of Expert Testimony*, JUDGES' J., Winter 1998, at 4, 8.

262 *See* discussion *supra* Section I.A.

263 *See* BUSH ET AL., *supra* note 45, at 114 ("Psychologists are advised to be vigilant to attorneys' efforts, throughout the provision of psychological services, to induce them to take on multiple roles . . . .").

264 Bruce D. Sales & Daniel W. Shuman, Editorial, *Reclaiming the Integrity of Science in Expert Witnessing*, 3 ETHICS & BEHAV. 223, 225 (1993).

265 *See, e.g.*, Shuman & Greenberg, *supra* note 261, at 6 ("We suggest that ethical rules and guidelines may assist the courts in this task by serving as red flags to raise potential problems of the reliability of expert testimony.").

266 *Id.*

267 *See* Baskerville v. Culligan Int'l Co., No. 93 C 5367, 1994 WL 162800, at *3 (N.D. Ill. Apr. 25, 1994).

International Co., the plaintiff called her treating psychologist, who was also her sister, to testify on her behalf in a sexual harassment lawsuit.[268] The defendant argued that the psychologist's testimony violated the American Psychology Association's ethical guidelines, which require psychologists to refrain from taking on professional roles that could reasonably "impair their objectivity, competence, or effectiveness in performing their functions as psychologists" and should be excluded.[269] The court rejected this argument and instead held that it went to the sister's credibility and was, therefore, an appropriate subject for cross-examination.[270]

Courts do apply professional ethical norms in other contexts, however. For instance, many courts hold that rules of professional responsibility can be considered in determining the standard of care in legal malpractice suits.[271] Furthermore, at least one court has held that "violations of the [Model Rules of Professional Conduct] create a rebuttable presumption of legal malpractice."[272] Numerous courts have found that counselors who engage in sexual relations with their patients in violation of ethical guidelines prohibiting such a practice, have engaged in professional negligence.[273] In the case of forensic psychiatric testimony, however, courts "have been reluctant to apply professional ethical norms to the decision to admit expert testimony, even when these norms express professional consensus about what is minimally necessary to present reliable professional information."[274]

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268 *Id.*

269 APA GENERAL PRINCIPLES, *supra* note 72, § 3.06 (Conflict of Interest); *see also Baskerville*, 1994 WL 162800, at *3.

270 *Baskerville*, 1994 WL 162800, at *3 ("If at trial the court determines that Dr. Bell may testify as an expert, the court would not be sponsoring her testimony or vouching for its objectivity. Rather, it would be the jury's function to assess the credibility of Dr. Bell's opinions and to determine the weight to be given her testimony.").

271 *See* Mainor v. Nault, 101 P.3d 308, 320 (Nev. 2004) (holding that a "violation of professional rules of responsibility does not create a private right of action, but is relevant to the standard of care"); *see also* Sears, Roebuck & Co. v. Goldstone & Sudalter, P.C., 128 F.3d 10, 19 (1st Cir. 1997) ("Violations of the rules governing the legal profession are evidence of legal malpractice . . . ."); Krischbaum v. Dillon, 567 N.E.2d 1291, 1301 (Ohio 1991) (holding that the Code of Professional Responsibility creates "norms of behavior, the violation of which may be deemed to be actionable upon the theory that the violator has not acted with due care").

272 Hart v. Comerica Bank, 957 F. Supp. 958, 981 (E.D. Mich. 1997).

273 *See, e.g.*, Weaver v. Union Carbide Corp., 378 S.E.2d 105, 107 (W. Va. 1989) (citing various cases). The *Weaver* court cited to the Second Restatement of Torts in support of this finding, which provides that "[u]nless he represents that he has greater or less skill or knowledge, one who undertakes to render services in the practice of a profession or trade is required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities." *Id.* at 107 n.4 (quoting RESTATEMENT (SECOND) OF TORTS § 299A (AM. LAW INST. 1965)).

274 Shuman & Greenberg, *supra* note 261, at 6. For example, in *Barefoot v. Estelle*, the American Psychiatric Association submitted an amicus brief arguing that the forensic psychiatrist in the case should not have been permitted to testify regarding the defendant's

FRE 702 and *Daubert* require exactly this kind of guidance from the relevant professional standards. The mental health field is unique in that it is a system entirely separate from the legal system, yet it is one the legal system regularly tasks with providing information necessary to reach legal decisions. Although *Daubert* makes it clear that "a rigid 'general acceptance' requirement would be at odds with the 'liberal thrust' of the Federal Rules and their 'general approach of relaxing the traditional barriers to "opinion" testimony,'"[275] courts are still permitted to consider the general acceptance requirement and should view testimony that is not generally accepted by the relevant scientific community "with skepticism."[276]

Furthermore, while FRE 702 and *Daubert* do not explicitly address forensic mental health testimony and do not distinguish between a treating physician and a retained forensic expert, the Federal Rules of Civil Procedure (FRCP) do draw such a distinction in Rule 26(a)(2), which requires parties to disclose expert witnesses who are expected to testify in the case.[277] FRCP 26 requires expert witnesses to make a report, but several courts have found that "a treating physician, testifying as to his consultation with or treatment of a patient, is not an expert witness under Rule 26."[278] This distinction is significant because it is based on the fact that when a treating psychiatrist provides testimony in a legal proceeding, "he has functioned as a direct participant in the events at issue" and is therefore "an actor with regards to the occurrences from which the tapestry of the lawsuit was woven."[279] The methods that produced his testimony, in other words, are not

probability of future dangerousness based solely on a series of hypotheticals and should have instead conducted "an in-depth psychiatric examination and evaluation." Brief for the American Psychiatric Association as Amicus Curiae at 6, 7, Barefoot v. Estelle, 463 U.S. 880 (1983) (No. 82-6080) (noting that the "diagnostic technique employed by the prosecution psychiatrists in this case is completely unacceptable"). Notwithstanding the APA's objections based on psychiatric best practices, the United States Supreme Court held that psychiatric testimony need not "be based on personal examination of the defendant" but may "be given in response to hypothetical questions." *Barefoot*, 463 U.S. at 903.

275 Daubert v. Merrell Dow Pharm., 509 U.S. 579, 588 (1993) (quoting Beech Aircraft Corp. v. Rainey, 488 U.S. 153, 169 (1988)).

276 *Id.* at 594.

277 FED. R. CIV. P. 26(2)(2). The advisory committee note to FRCP 26 further distinguishes treating physicians from retained forensic experts by clarifying that "[a] treating physician, for example, can be deposed or called to testify at trial without any requirement for a written report." FED. R. CIV. P. 26 advisory committee's note to 1993 amendment.

278 Gonzalez v. Exec. Airlines, Inc., 236 F.R.D. 73, 77 (D.P.R. 2006); *see also* Rogers v. Detroit Edison Co., 328 F. Supp. 2d 687, 690 (E.D. Mich. 2004) (finding in a negligence action that an expert who was testifying as the plaintiff's treating psychologist was not required to file a FRCP 26 expert report).

279 *Gonzalez*, 236 F.R.D. at 77 (quoting Gomez v. Rivera Rodriguez, 344 F.3d 103, 113 (1st Cir. 2003)).

methodologically sound and the treating psychiatrist should not be characterized as an expert.

While the Federal Rules of Evidence may not prohibit expert testimony by a treating clinician, courts considering testimony under the rules should not permit testimony from a mental health professional who has become an actor in the case through her involvement in the patient's treatment. In effect, she is evaluating her own role in the patient's treatment and current mental state. As one author put it, "Only by not being a person whose actions influence the mental status or condition of the litigant can the forensic expert offer an independent opinion regarding the litigant's mental status or condition."[280] The underlying methodology of such an approach is unsound and should not be admitted.

The mental health community has reached a general consensus that dual forensic and clinical relationships lead to conflicts of interest, bias, and harm to the therapeutic relationship.[281] Moreover, this bias is often unconscious and cannot be eliminated.[282] Testimony is inherently unreliable and should not be admissible under FRE 702 when it is premised upon information a clinician learns while participating in a dual relationship with a single patient. Although there is widespread agreement among mental health professionals that this sort of testimony is troubling and "problematic at best,"[283] courts have not taken the view of the mental health community into account when ruling on the admissibility of forensic mental health testimony. Whether this is because courts are unaware of the testimony's unreliability, or because some mental health professionals are willing to relax professional standards and boundaries if they feel a court will not question those professional ethics, the practice should not be permitted to continue.

B. *Courts and States Should Permit Forensic Evaluations via Telebehavioral Health*

One reason for dual forensic and clinical relationships is the shortage of qualified mental health professionals throughout the United States. One recent study found that seventy-seven percent of counties in the United States had a "severe shortage" of psychiatrists and other

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280 Stuart A. Greenberg & Daniel W. Shuman, *When Worlds Collide: Therapeutic and Forensic Roles*, 38 PROF. PSYCHOL. RES. & PRAC. 129, 130 (2007). The authors also state, "When a therapist also serves as a forensic expert, the therapist is part of the fabric of the case, in part evaluating the impact of his or her own participation." *Id.*

281 *See supra* Sections II.A–B.

282 *See supra* Section II.C.

283 APPELBAUM & GUTHEIL, *supra* note 20, at 235.

mental health professionals, with "over half their need [for mental health services] unmet."[284] The problem is particularly acute in rural areas. A report on the U.S. physician workforce found that in 2005, only 11.4% of physicians practiced in rural areas; the number of psychiatrists in those areas accounts for only 8.7% of all licensed psychiatrists in the United States.[285]

The American Psychiatric Association has endorsed telepsychiatry—or telebehavioral health—as a way to provide mental health care and forensic evaluations in underserved areas, especially those with provider shortages.[286] Telecommunication technologies are used to treat and evaluate mental health patients from a distance.[287] Within the mental health professions, live videoconferencing, as opposed to other communication forms like email and telephone communication, is the most commonly used medium, and the one most conducive to the practice of psychiatry and psychology.[288] Research has found that "psychiatric consultation and short-term follow up provided by telepsychiatry can produce clinical outcomes that are equivalent to those achievable when patients are seen face to face."[289] In remote areas, or those without access to a large psychiatric workforce, telepsychiatry can also be less expensive than services provided in person.[290] Points of delivery for telepsychiatry can include hospitals, clinics, prisons, or any setting with secure videoconferencing equipment.[291]

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284 Kathleen C. Thomas et al., *County-Level Estimates of Mental Health Professional Shortage in the United States*, 60 PSYCHIATRIC SERVICES 1323, 1325 (2009). The study included prescribers, including psychiatrists, and nonprescribers, including other mental health professionals such as psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, and marriage and family therapists. *Id.* at 1324.

285 *See* FREDERICK M. CHEN ET AL., RURAL HEALTH RESEARCH CTR., U.S. RURAL PHYSICIAN WORKFORCE: ANALYSIS OF MEDICAL SCHOOL GRADUATES FROM 1988–1997, at 6 tbl.2 (2008), http://depts.washington.edu/uwrhrc/uploads/RHRC%20FR113%20Chen.pdf.

286 *See Underserved Communities: Rural and Telepsychiatry Resources*, AM. PSYCHIATRIC ASS'N, http://www.psychiatry.org/psychiatrists/cultural-competency/underserved-communities (last visited Feb. 4, 2016).

287 *See* Diana J. Antonacci et al., *Empirical Evidence on the Use and Effectiveness of Telepsychiatry Via Videoconferencing: Implications for Forensic and Correctional Psychiatry*, 26 BEHAV. SCI. & L. 253, 253 (2008).

288 *See id.* at 254.

289 Richard O'Reilly et al., *Is Telepsychiatry Equivalent to Face-to-Face Psychiatry? Results from a Randomized Controlled Equivalence Trial*, 58 PSYCHIATRIC SERVICES 836, 842 (2007).

290 *See id.* at 841.

291 The American Psychiatric Association has created an extensive resource document for practitioners that addresses various implementation issues related to telepsychiatry, including available technology, security protocols, and the confidentiality of patient information. *See* APA COUNCIL ON PSYCHIATRY & L., AM. PSYCHIATRIC ASS'N, RESOURCE DOCUMENT ON TELEPSYCHIATRY AND RELATED TECHNOLOGIES IN CLINICAL PSYCHIATRY (2014). Several legal issues also arise with the use of telepsychiatry, primarily privacy and confidentiality, as well as licensing requirements governing psychiatrists located outside of the state where treatment is

Furthermore, recent studies suggest that the use of telebehavioral health is an appropriate option in correctional settings, where it is frequently used for competency evaluations.[292] Studies suggest these evaluations are as reliable as in person evaluations, and both users and prisoners report they are satisfied with telepsychiatry.[293] In particular, one study found that some prison inmates prefer telepsychiatry consultations for discussing sexual abuse issues.[294] Finally, the use of telepsychiatry in forensic competency evaluations is one way to reduce the cost of transporting defendants to a location where a forensic evaluation can be performed.[295]

Although most states have enacted statutes related to telehealth, access and coverage vary widely.[296] While a few states explicitly permit the use of telebehavioral health or telepsychiatry,[297] most that allow for the practice define telebehavioral health within the context of a more comprehensive "telehealth" statute[298] or rely on other statutes allowing for temporary or guest practices—courtesy licenses—to permit for the use of telemedicine by mental health professionals located outside of the state.[299] A few states without comprehensive telehealth statutes simply

provided. For an overview of some of those concerns, see Regina A. Bailey, *The Legal, Financial, and Ethical Implications of Online Medical Consultations*, 16 J. TECH. L. & POL'Y 53 (2011).

292 *See* Antonacci et al., *supra* note 287, at 265–66.

293 *See id.* Another recent study of seventy-two forensic outpatient interviews found similar results for in person and video interviews on both the Brief Psychiatric Rating Scale-Anchored Version and the MacArthur Competence Assessment Tool-Criminal Adjudication and concluded that "providers can expect remote interviews to provide clinical information similar to that obtained by interviews conducted in person." Frances J. Lexcen et al., *Use of Video Conferencing for Psychiatric and Forensic Evaluations*, 57 PSYCHIATRIC SERVICES 713, 713–15 (2006).

294 *See* William Tucker et al., *A Pilot Survey of Inmate Preferences for On-Site, Visiting Consultant, and Telemedicine Psychiatric Services*, 11 CNS SPECTRUMS 783, 785 (2006).

295 *See* Lexcen et al., *supra* note 293, at 713.

296 For a recent summary of state legislative efforts in regards to telehealth, see AM. TELEMEDICINE ASS'N, 2016 STATE TELEMEDICINE LEGISLATION TRACKING (2016), http://www.americantelemed.org/docs/default-source/policy/state-legislation-matrix_2016B329BF4CEB13AA9A5AF24FC424BFE8AEF0B0.pdf?sfvrsn=6.

297 *See, e.g.*, 24 DEL. ADMIN. CODE § 3500–18.1 (2013) ("'Telepsychology' means the practice of psychology by distance communication technology such as but not necessarily limited to telephone, email, Internet-based communications, and videoconferencing."); OHIO REV. CODE ANN. § 4732.01(J) (West 2013) ("'Telepsychology' means the practice of psychology or school psychology by distance communication technology, including telephone, electronic mail, internet-based communications, and video conferencing."). For a comprehensive review of telepsychology statutes among states, see AM. PSYCHOLOGICAL ASS'N, TELEPSYCHOLOGY 50-STATE REVIEW (2013) [hereinafter TELEPSYCHOLOGY 50-STATE REVIEW], http://www.apapracticecentral.org/advocacy/state/telehealth-slides.pdf.

298 *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3601 (2014) (providing that psychologists are included as "Health care provider[s]" who may practice telemedicine in the state).

299 Colorado, for instance, does not have a dedicated telepsychology statute, but allows for the "delivery of health services by other licensed professionals, within the professional's scope of practice, using advanced technology, including, but not limited to, interactive audio, interactive video, or interactive data communication." COLO. REV. STAT. § 12-36-106(1)(g)

allow for courtesy licenses for mental health professionals licensed out of state and define "psychological services" to include the provision of all psychological services by those professionals, regardless of whether the professional is temporarily located in the state or is providing services by electronic or telephonic means from the state where the professional is licensed.[300] States vary in their approach to licensing requirements for professionals licensed out-of-state, but all require such practitioners to be licensed to practice in their own state, in any state, or in any state where the state requirements exceed those of the state in which they are providing services.[301] Finally, some states allow only a psychologist or psychiatrist who is licensed in the state to provide mental health services via telemedicine.[302]

In many states, the most direct ways to implement telebehavioral health for mental health professionals are to amend an existing telehealth statute to include the practice of psychology and psychiatry, or to create a new statute that explicitly allows telebehavioral health. Similarly, to expand the pool of available practitioners, states that allow only psychiatrists and psychologists located within the state to practice telemedicine could remove those restrictions. In states with strict courtesy licensing requirements, these requirements could be relaxed. For instance, in Alaska, psychologists may obtain a courtesy license to practice for no more than thirty days in a twelve-month period, but may receive only one courtesy license in their lifetime.[303] Similarly, psychiatrists and other medical doctors in Alaska may receive a courtesy license only under very limited circumstances, including the provision of emergency health or mental health services in response to a disaster, or the accompaniment of an out-of-state sports team to a sporting event.[304] For psychiatrists and physicians in that state, there is no general provision allowing medical doctors to receive a courtesy license to practice medicine. If these courtesy licensing requirements were

(2015). The state also allows for a psychologist who resides in another state and is currently licensed as a psychologist in that state to provide services to patients in Colorado under certain circumstances. If the activities and services are performed within the scope of the person's license or certification, do not exceed twenty days a year, and disclosure is given to the patient that the psychologist is not licensed in the state, then a psychologist licensed in another state can provide services in Colorado. *See id.* § 12-43-215(9).

300 *See, e.g.*, WIS. STAT. § 455.03 (2014); WIS. ADMIN. CODE PSY. § 2.14(1) (2016).

301 *See* TELEPSYCHOLOGY 50-STATE REVIEW, *supra* note 297.

302 *See, e.g.*, CAL. BUS. & PROF. CODE § 2290.5(a)(3) (West 2012) ("'Health care provider' means . . . [a] person who is licensed under this division.").

303 *See* ALASKA ADMIN. CODE tit. 12, § 60.035(c) (2016). The individual must provide verification of a current license to practice psychology in another jurisdiction for the scope of practice specified in the application, and provide verification of having passed the EPPP examination. *See id.*

304 *See id.* § 40.045(b) (2016). Other allowable purposes include conducting a specialty clinic or accompanying a patient who is also the physician's employer. *See id.*

relaxed, however, psychologists and psychiatrists located out of state could perform forensic evaluations within the state after receiving a courtesy license.

Apart from licensing requirements, another barrier to the provision of telebehavioral health is the unwillingness of professionals to use it.[305] Part of this resistance is likely due to mental health professionals' lack of experience with the relevant technology. As telemedicine has become more prevalent, some medical schools have begun to include telemedicine education,[306] and some institutions have begun to offer training to practicing physicians and other health care providers.[307] But more education and training is needed.[308] When telemedicine becomes a standard component of medical education, some of these concerns are likely to dissipate.

Some clinicians also express concern that the use of videoconferencing equipment could have an impact on the therapeutic relationship.[309] Yet studies of telebehavioral health have found "no apparent impairment of the working alliance" when therapy was delivered via interactive video.[310] Moreover, in the forensic setting, the mental health professional is not attempting to form a therapeutic relationship with the evaluee. Instead, her role is to "gather and present objective information that may ultimately aid a trier of fact . . . to reach a just solution to a legal conflict."[311] Telebehavioral health is an appropriate way to conduct that forensic evaluation and could reduce the frequency of dual-role relationships.[312]

Telebehavioral health is one of the fastest-growing applications of telemedicine in the United States and "[m]ental health is particularly suited to the use of advanced communication technologies and the

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305 Carl May et al., *Resisting and Promoting New Technologies in Clinical Practice: The Case of Telepsychiatry*, 52 SOC. SCI. & MED. 1889, 1895–96 (2001).

306 *See, e.g.*, *Telehealth Leadership Fellowship*, T. JEFFERSON U., http://www.jefferson.edu/university/jmc/departments/emergency_medicine/education/fellowships/telehealth_leadership.html (last visited Feb. 4, 2016).

307 *See, e.g.*, *Continuing Medical Education Credits*, U.C. DAVIS HEALTH SYS., http://www.ucdmc.ucdavis.edu/cht/education/telehealth/cme.html (last visited Feb. 4, 2016).

308 *See generally* José G. Conde et al., *Telehealth Innovations in Health Education and Training*, 16 TELEMEDICINE J. & E-HEALTH 103 (2010).

309 *See* May et al., *supra* note 305, at 1895–96 ("Ideas about the 'impersonality' or 'lack of spontaneity' experienced in using the videophone run through [psychiatrist's] accounts" of telemedicine and mentioning that some psychiatrists also noted "the failure of the system to adequately mediate the emotional reality of situations, or to permit 'natural' interactions.").

310 M. Manchanda & P. McLaren, *Cognitive Behaviour Therapy Via Interactive Video*, 4 J. TELEMEDICINE & TELECARE 53, 53 (1998).

311 Greenberg & Shuman, *supra* note 120, at 54.

312 *See Underserved Communities: Rural and Telepsychiatry Resources*, *supra* note 286.

Internet for delivery of care."[313] Moreover, numerous guidelines exist that provide for appropriate clinical, technical, and ethical use.[314] Finally, telebehavioral health has the potential to provide mental health access to individuals in areas throughout the United States, and its continued and expansive use is one way to reduce mental health professionals' and courts' reliance on unreliable forensic mental health testimony.

C. *Courts Should Make Greater Use of FRE 706 to Appoint Independent Mental Health Experts*

The goal of protecting jurors from unreliable expert testimony is, of course, not unique to the United States, and courts around the world have struggled to create an appropriate standard for the admission of expert testimony.[315] In adversarial systems like the United States, courts impose fewer restrictions on the admissibility of expert testimony and rely on cross-examination to expose jurors to major weaknesses in expert testimony.[316] Because both sides of the lawsuit present competing stories, and these stories are often supported by expert testimony, the factfinder is free to decide which expert is more credible.

In contrast, in inquisitorial systems like those in many European countries, experts are often appointed by the court and "little attempt is made to point out weaknesses of the expert testimony to the ultimate fact-finder, the judge."[317] In Germany, for example, "the court selects the expert . . . [from a prepared] list of experts."[318] This expert must be neutral and independent of the parties.[319] The judge asks the majority of the questions, and when the attorneys do question the witness, it "can be described as a polite questioning in a non-confrontational

313 AM. TELEMEDICINE ASS'N, PRACTICE GUIDELINES FOR VIDEO-BASED ONLINE MENTAL HEALTH SERVICES 7 (2013), http://www.americantelemed.org/docs/default-source/standards/practice-guidelines-for-video-based-online-mental-health-services.pdf?sfvrsn=6.

314 *See id.* at 8–19.

315 *See* Krauss et al., *supra* note 114, at 2.

316 *See* Vidmar & Laird, *supra* note 207, at 888–89.

317 Krauss et al., *supra* note 114, at 3.

318 Sven Timmerbeil, *The Role of Expert Witnesses in German and U.S. Civil Litigation*, 9 ANN. SURV. INT'L & COMP. L. 163, 173 (2003).

319 *Id.* at 174.

atmosphere."[320] When parties do hire outside experts, their opinions are given less weight because the experts' opinions are not considered reliable.[321]

Although many scholars believe that an adversarial system better safeguards procedural justice,[322] others still question the propriety of adversarial procedures for presenting expert testimony. As one author notes, "[c]ritics have argued that many problems associated with expert testimony result from features inherent in the adversarial process."[323] For example, because experts are well paid, this can advantage the party with greater resources.[324] The adversarial system also encourages the development of "professional experts," who may have ongoing relationships with certain parties and therefore are prone to allegiance bias.[325] Finally, the nature of the adversarial system often results in a "battle of experts," which can "confuse jurors and waste time at trial."[326] Put simply, "an expert witness may de1iver biased testimony simply because he or she has been hired by an attorney."[327]

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320 *Id.* at 175. As the author explains:

> [One] reason why the parties and their lawyers question the expert in such a deferential manner is obvious: the court appointed the expert and gave her orders during the proceedings. Attacking the expert would be equivalent to criticizing the judge's authority to select and question the expert—and in German civil courts, the judge is always the decision-maker.

Id.

321 *See id.* at 178 ("Courts usually doubt the reliability of partisan experts who are hired by the parties and have discussed the case with counsel."); *see also* Hein Kötz, *Civil Justice Systems in Europe and the United States*, 13 DUKE J. COMP. & INT'L L. 61, 64 (2003). Kötz explains his participation in various litigation as a court-appointed expert in a German court and an expert hired by a party in a British court:

> What struck me most in my role as party-selected expert witness in the English cases was not the experience of being examined and cross-examined, but the difficulty to resist the subtle temptation to join your client's team, to take your client's side, to conceal doubts, to overstate the strong and downplay the weak aspects of his case and to dampen any scruples you might have by reminding yourself that the other side will select and instruct another expert witness and that, when the dust has settled, the truth will triumph.

Id.

322 *See* Nancy J. Brekke et al., *Of Juries and Court-Appointed Experts: The Impact of Nonadversarial Versus Adversarial Expert Testimony*, 15 LAW & HUM. BEHAV. 451, 451–52 (1991) (discussing various studies). As the authors note, "[d]ecisions resulting from adversarial procedures are perceived as more just and fair than decisions resulting from nonadversarial alternatives." *Id.* at 452.

323 *Id.* at 452.

324 *See id.*

325 *Id.*; *see also supra* text accompanying notes 206–13.

326 Brekke et al., *supra* note 322, at 452.

327 *Id.* at 453.

FRE 706 allows courts to appoint neutral and independent experts[328] and *Daubert* itself noted that "Rule 706 allows the court at its discretion to procure the assistance of an expert of its own choosing."[329] Yet court-appointed experts are infrequently used,[330] and many court decisions attribute this reluctance to respect for the adversarial system.[331] However, one study of 431 federal district court judges found that twenty percent had appointed an expert on one or more occasions.[332] In many cases, judges felt that a court-appointed expert was necessary when the parties failed to present credible witnesses and "[a]ppointment of an independent expert enabled access to testimony that was thought to be both impartial and necessary to understand the testimony of the parties' experts."[333]

Although some scholars have objected to court-appointed experts because they fear that jurors will be biased in favor of such testimony,[334] one study of mock jurors did not find this type of bias.[335] When mock jurors were presented with evidence from both court-appointed (nonadversarial) and attorney-hired (adversarial) experts, the "[c]court-appointed status did not boost the expert's credibility," and "nonadversarial evidence was not automatically accorded favored status in jurors' minds."[336] On the contrary, jurors who heard testimony from court-appointed experts tended to pay slightly less attention than those

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328 *See* FED. R. EVID. 706(a) ("The court may appoint any expert that the parties agree on and any of its own choosing.").

329 Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 595 (1993).

330 *See* JOE S. CECIL & THOMAS E. WILLGING, FED. JUDICIAL CTR., COURT-APPOINTED EXPERTS: DEFINING THE ROLE OF EXPERTS APPOINTED UNDER FEDERAL RULE OF EVIDENCE 706, at 7 (1993) ("[T]he use of court-appointed experts appears to be rare . . . ."); *see also* Reilly v. United States, 863 F.2d 149, 156–57 (1st Cir. 1988) ("Appropriate instances, we suspect, will be hen's-teeth rare.").

331 *See* CECIL & WILLGING, *supra* note 330, at 5 ("Judges view the appointment of an expert as an extraordinary activity that is appropriate only in rare instances in which the traditional adversarial process has failed to permit an informed assessment of the facts."); *see also* McCracken v. Ford Motor Co., 392 F. App'x 1, 4 (3d Cir. 2010) (stating that the use of court-appointed experts is rare because it "interferes with adversarial control over the presentation of evidence" (quoting 29 CHARLES ALAN WRIGHT & VICTOR GOLD, FEDERAL PRACTICE AND PROCEDURE § 6304 (1st ed.)); *In re* Joint E. & S. Dists. Asbestos Litig., 830 F. Supp. 686, 693 (E.D.N.Y. 1993) ("Rule 706 should be reserved for exceptional cases in which the ordinary adversary process does not suffice . . . .").

332 *See* CECIL & WILLGING, *supra* note 330, at 7 ("The figures indicate that, taken together, these judges made approximately 225 appointments, far more than suggested by the paucity of published opinions dealing with the exercise of this authority.").

333 *Id.* at 13.

334 *See* Brekke et al., *supra* note 322, at 468; *see also* FED. R. EVID. 706 advisory committee's note to 1972 proposed rules ("[T]he contention is made that court appointed experts acquire an aura of infallibility to which they are not entitled," but "the trend is increasingly to provide for their use").

335 *See* Brekke et al., *supra* note 322, at 468.

336 *Id.*

who heard testimony from adversarial experts and had poorer recall of information that court-appointed experts provided.[337] As the authors note, this somewhat ironic result suggests that "[c]ourt-appointed experts may, in fact, deliver more accurate, unbiased testimony than their adversarial counterparts, but this increased accuracy may be lost on jurors who are no longer paying careful attention to the expert's testimony."[338] These findings suggest that jurors should not be told that a particular expert is court appointed.

Finally, greater use of court-appointed experts could minimize some of the effects of the adversarial system on expert testimony. Judges would be motivated to appoint well-credentialed and respected experts within their communities, and experts would be paid by the court, thus reducing bias against parties with fewer financial resources.[339] If court-appointed experts were regularly used, this could lead to fewer "hired guns," thus reducing allegiance bias and "battles between experts."[340] Attorneys would still be permitted to call their own experts, but many may choose to simply rely on the court-appointed experts.[341] Perhaps most importantly, "[t]he nonadversarial role of the court-appointed expert should enable the expert to give the most impartial and unbiased testimony possible" and "could represent a significant improvement over the current adversarial procedure for introducing experts."[342]

CONCLUSION

The mental health community overwhelmingly believes that dual forensic and clinical relationships lead to conflicts of interest, bias, and harm to the therapeutic relationship. Moreover, this bias is often unconscious and cannot be eliminated. Testimony premised upon information that a clinician learns while participating in dual relationships with one patient is therefore inherently unreliable and should not be admissible under FRE 702 or *Daubert*. Although there is widespread agreement among mental health professionals that this sort of testimony is troubling, unethical, and unreliable, courts have not taken the view of the relevant scientific community into account when ruling on the admissibility of this type of expert testimony. Whether this is because courts are unaware of the testimony's unreliability, or because some mental health professionals are willing to relax professional

337 *See id.* at 469–70.
338 *Id.* at 470.
339 *Id.* at 453–54.
340 *Id.* at 454.
341 *Id.*
342 *Id.*

standards and boundaries if they feel a court will not question those professional ethics, the practice should not be permitted to continue.

The admission of forensic mental health testimony based on dual relationships should be excluded as unreliable under FRE 702. States should adopt or amend statutes allowing the practice of telebehavioral health to allow for greater use of neutral and independent forensic mental health evaluations, and courts should consider the greater use of FRE 706 to appoint neutral and independent mental health evaluators in legal proceedings.